The Modern Hospital

NOVEMBER 1958

Survey Reveals Public Attitudes Toward Hospitals and Blue Cross

Hospitals are doing a "fair to good" job, but they could be warmer and friendlier; many believe the government should pay a larger share of hospital bills—page 65

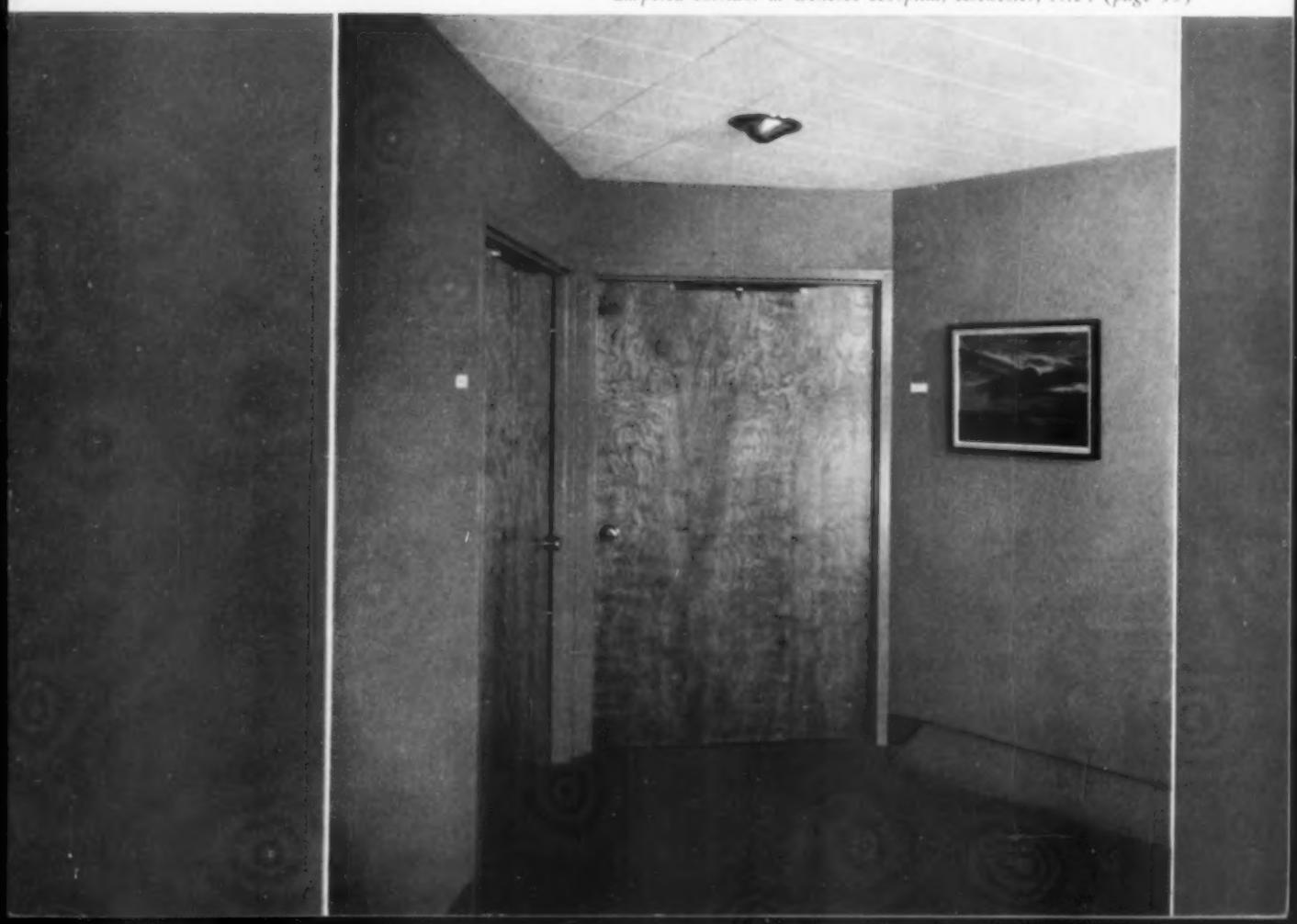
Circular Nursing Division Runs Rings Around Rectangles

Observations made during this careful experiment at Rochester indicate circular unit may be just the thing for intensive nursing care—page 71

Sales Representatives Have Something To Teach — and Learn

Salesmen calling on hospitals may help the administrator and purchasing agent, or they may just waste time; here are some rules for the relationship—page 98

Carpeted corridor at Genesee Hospital, Rochester, N.Y. (page 95)



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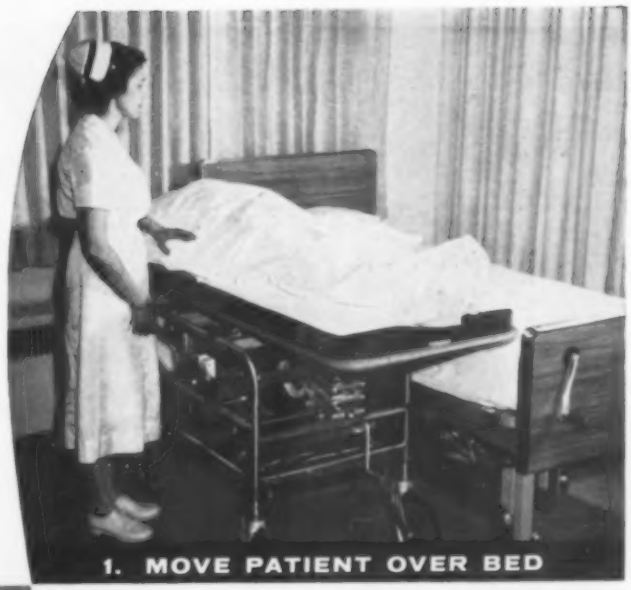
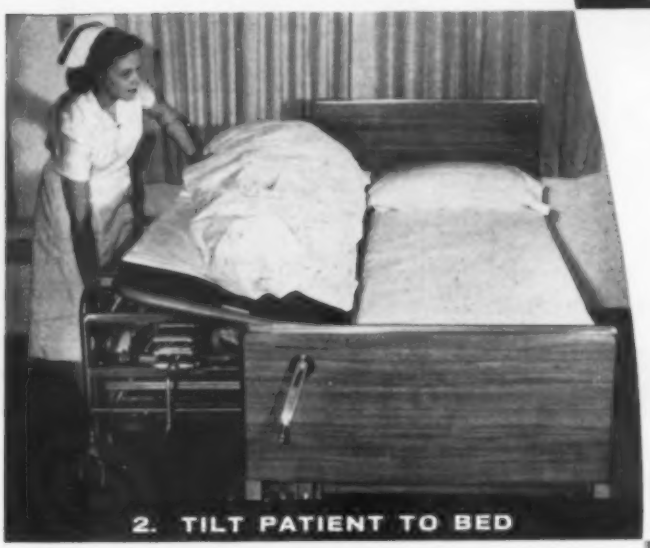


1. MOVE PATIENT OVER BED



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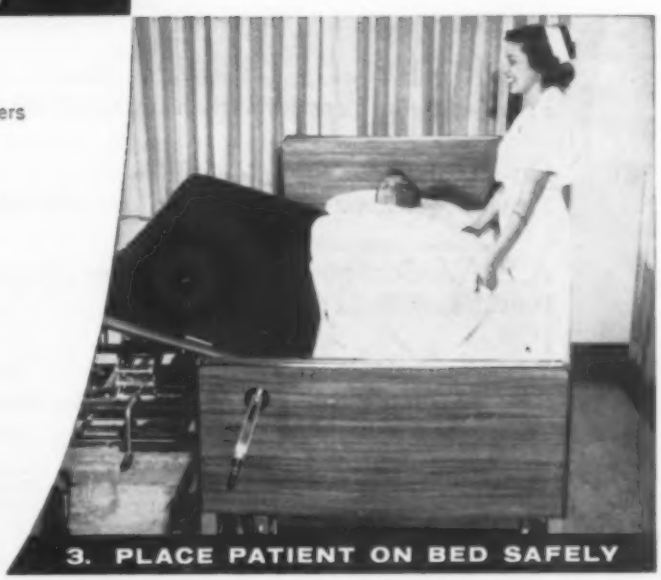

3. PLACE PATIENT ON BED SAFELY

The Modern Hospital

NOVEMBER 1958 VOLUME 91, NO. 5

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ROVING REPORTER

Hospital Helps Strike-Bound Employes Get To Work

What happens to a hospital when its employes are not able to get to their jobs? In areas where large numbers of hospital employes depend on public transportation, a subway or bus strike could pose a serious problem.

Memorial Center for Cancer and Allied Diseases in New York City, with 1450 employes, faced this problem when a subway workers' union went on strike. Advance planning, initiated by Richard D. Vanderwarker, vice president and general manager of the hospital, alleviated the situation.

An emergency organization, headed by a disaster coordinator, divided the problem into four areas: (1) determination of essential services, so employes from other divisions could be assigned to staff them; (2) arrangements for alternative transportation for essential personnel; (3) provisions for housing employes who could not go back and forth during the strike, and (4) additional parking for employes who drove to the Center.

Each division manager met with his department heads and implemented his section of the program. Each department head determined which of his subordinates would be unable to get to work because of lack of transportation. He was then asked to determine which of those unable to get to work were essential to the operation of the department. Within each department, individuals were encouraged to determine their transportation needs and establish car pools, spend the night with friends living in the area, and take on extra work when necessary.

If the department heads were unable to handle the problems of transportation, parking, staffing or housing, they were to contact the emergency department assigned to that particular area.

Center of Activity

The transportation office was the main center of activity. It was established in the personnel office to provide easy access to personnel records. The personnel officer was the supervisor in charge of transportation and the administrative resident was in charge of the transportation office and its operation.

The office was divided into sections to handle car pools, emergency taxi service for key personnel, emergency bus service, transportation routing, and transportation news. The New York subway system, possible emergency bus routes sponsored by the Center, and available and requested automobile service were plotted on a map of the area. Continuous contact was maintained with the police department, transit authority, and the local press.

A listing of all personnel by department and location was obtained to assist in the determination of transportation needs. As calls were received offering or requesting automobile transportation, the information was placed on 3 by 5 inch cards and plotted on the map with colored pins. Departments were asked to furnish employe's name, address, location of home, route used by automobile, home telephone

Patient's room, Genesee Hospital, Rochester, N. Y. Interior design by Hospital Furniture, Inc. Colin Campbell McLean, Pres.

Seamloc makes hospitals more home-like

Colin Campbell McLean, one of the country's leading hospital decorators, has used Seamloc carpet as a base on which to build his decorative scheme and thus created a warm non-institutional feeling in the Genesee Hospital.

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number, hospital extension number, days and hours worked, number of passengers that could be carried, and name of department making the request.

When possible, individuals requesting transportation were furnished the telephone number of a person with transportation available. If none was available, individuals were routed over existing public transportation. If this was impractical, and if the department considered the employe essential, a call was made to the emergency transportation pool. Bus routes were established in areas not fed by emergency subway service, with pickup points spotted in areas in which there was a heavy concentration of employes.

Several hundred individuals were serviced with car pools, transportation routing directions, and information concerning transportation available and progress of the strike.

Approximately 100 employes used the available bus transportation service, 10 were served by the emergency taxi service, and about 25 parking spaces were used by the drivers in the car pool.

The housing problem was partially solved by persons staying with friends in the area. Ten employes were provided beds at the Center and four were furnished hotel accommodations near by.

Since the strike did not develop to as serious proportions as had been anticipated, not all of the emergency measures planned by the Center were used. The program of emergency staffing was based on the theory that certain areas needed special concentration.

Services determined to be essential were: medical, nursing, dietary, engineering, laundry, information, telephone, pharmacy, housekeeping, diagnostic and therapeutic. If the situation had demanded, personnel would have been channeled to these critical areas from: administration, business office, clinics, general stores, medical library, medical records, photography and art, purchasing, receiving, social service, and statistics.

The policy outline provided that the clinics should operate at levels required by patient load and availability of staff, and would discontinue service if absolutely necessary to staff essential hospital services. This did not prove necessary.

Raised Employe Morale

As a result of the emergency transportation and housing program, employe attendance was nearly 100 per cent throughout the emergency. Since absenteeism was lower than usual, the administration believes that the program increased morale in addition to its tangible benefits. The feeling that, since the hospital was trying in every way to aid the employes, they should make increased efforts to get to work characterized employe reaction to the plan.

In addition to these benefits, the administration of the Center suggests that it benefited from the knowledge that prior planning pays off. Although the emergency system did not have to be utilized to the full extent, it was readily available if needed. Perhaps most important, a workable emergency plan had been established, tested and evaluated for future use.—GLENN A. WESSELMANN, *student in hospital administration, Sloan Institute Program, Cornell University.*

At the time this article was prepared, Mr. Wesselmann was administrative resident at Memorial Center for Cancer and Allied Diseases, New York.

(Text Continued on Next Page)

THE MAN WITH THE VESTAL PLAN

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Right: Administrator Sister Loretto Bernard shows a group of officials how new doghouse sign will record safety record of the departments. Red, yellow and green lights show which departments had no incidents resulting in loss of time, those with incidents but no time loss, and those without incidents.

Sign "Hounds" Offenders

Departments may be in the "doghouse" at St. Vincent's Hospital, New York, unless their safety records are incident-free. The "doghouse" is a part of an illuminated safety display which was unveiled at a Greater Safety Week Program by Sister Loretto Bernard, administrator.

Red, yellow and green display lights indicate by their positions on the sign which departments had incidents resulting in time losses, those with incidents but no time loss, and those with no incidents on their safety record for the month. Located at the employes' entrance, the display serves as a constant reminder.

As part of the annual safety week campaign a poster contest was held with prizes for the top nine artists. Daily during the week some phase of patient and employe safety was highlighted with special promotions to stimulate greater safety consciousness among employes.

They Remembered

More than 500 employes and administrators of other hospitals in Cleveland came to Lutheran Hospital for a surprise party on September 11 to honor Lee S. Lanpher, administrator, on completing 25 years as the hospital's chief executive.

The surprised administrator was led into the living room of the nurses' residence at the school of nursing by the chief of medicine, Dr. Myron August, and Chaplain Lester Draheim. In the room were friends, employes and the administrator's wife and his daughter, Jean, a student at Duke University, who were on hand to help him celebrate.

In addition to several gifts which were presented by representatives of the different groups present, a large album of more than 150 letters which had been sent by administrators of other hospitals throughout the country, many editors, and from the various national medical and hospital associations was presented to Mr. Lanpher.

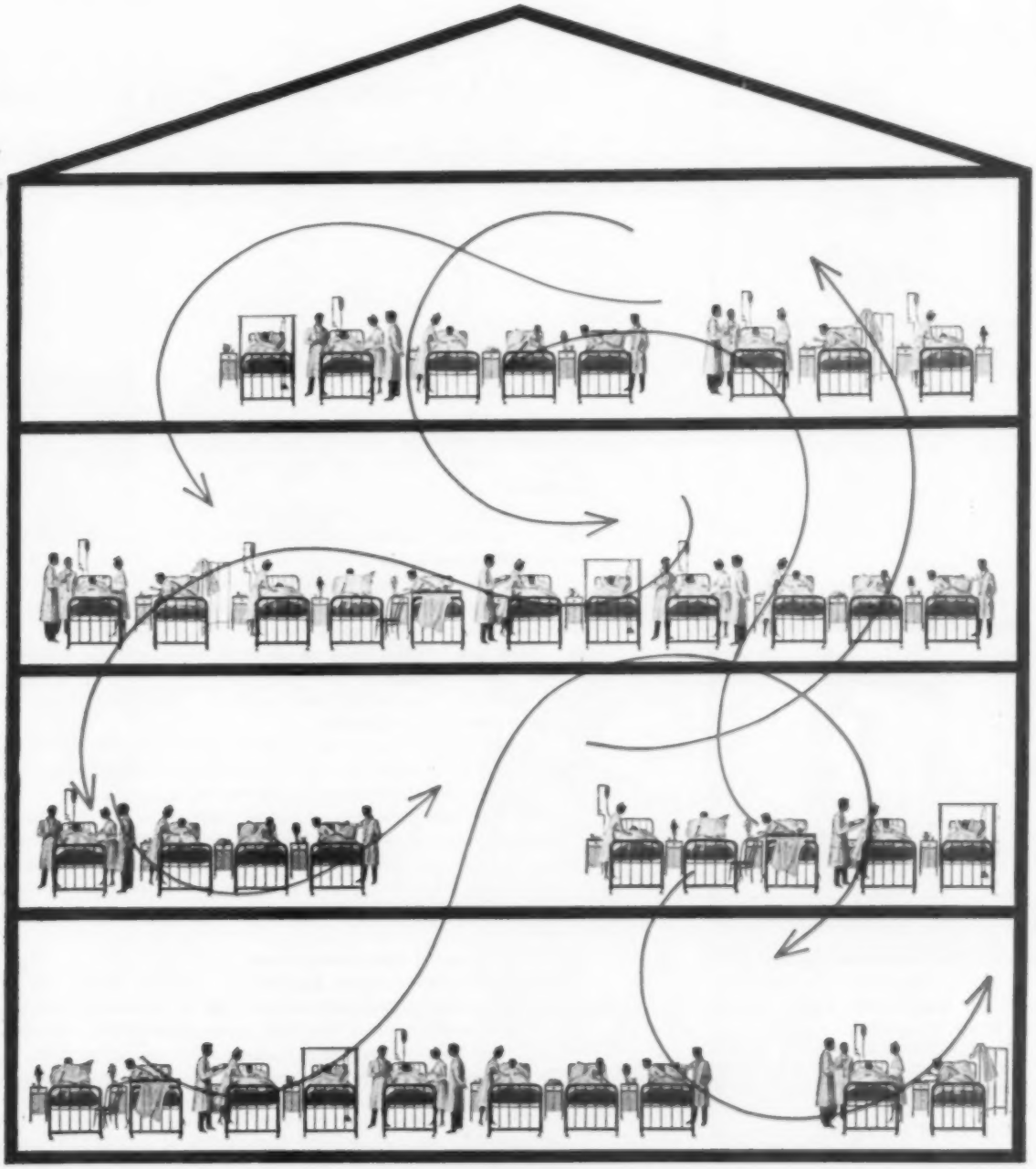
The surprise party was one of the best kept secrets in the hospital's history. The day before the party Mr. Lanpher walked into the admitting office to see Irene Strahosky, who was working there when he arrived. He mentioned that he was near the 25th anniversary and he was surprised that she hadn't remembered. The next day —he found out that she did.

They Change To Serve

Changing their green Girl Scout uniforms for red and white striped ones of teen-age hospital volunteers is a regular part of the program for Elgin Ill., Girl Scouts who serve at Sherman Hospital there.

The younger Girl Scouts serve in the snack bar, wash dishes, and make sandwiches. Senior Scouts work as elevator operators and floor aides, help fold and sort operating room linens, wash furniture in vacated rooms, and serve midmorning coffee to patients.

Their work earns them public service credits toward Girl Scout merit badges. Last year more than 60 girls participated in the program, according to Mrs. J. G. Massey, director of hospital volunteers.



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News Developments Offer a Chance To Tell Broader Story of Hospital

By Gordon Davis

Gordon Davis

DURING the course of a luncheon preceding a committee meeting, a well known hospital administrator spent some time detailing the tremendous amount of planning and behind-the-scenes work involved in open heart surgery in his institution.

The activity was new in the hospital in question, and its introduction had been reported with some enthusiasm in the press.

"The trouble is," the administrator complained, "the public is interested only in the dramatic side of heart surgery. The people have no idea of the extra burden and expense this means to our hospital."

"Did you tell the reporters about it when you were talking to them?" someone asked.

"Well, no," the administrator replied. "They didn't ask us, and we didn't think of it at the time."

In other words, one of the valuable opportunities offered by this particular news development was passed by completely. Unfortunately, this often seems to be more the rule than the exception.

As has been previously observed, publicity is not the foremost public relations tool available to the hospital, but this does not mean that it should be either shunned or aimless. On the contrary, news announcements and stories need to be analyzed with care for their potential contributions to the hospital's basic public relations objectives.

If the hospital in our example merely wished to enhance its prestige, then the story as it was handled was probably worth while. But if its public relations purposes included better community education in the relationship between costs and services, for instance, the details should have been worked out in advance down to the last dollar and fully communicated to the reporters. Moreover, the details would have made a better news story and thereby have elevated prestige.

Failure to set specific objectives, preferably in writing, and to concentrate on the measures that will contribute most toward serving the objectives, is responsible for a great deal of waste motion and loss of opportunity in publicity as in all public relations activities. It's a little like starting on a trip without knowing your destination.

What is it that the people most need to know about your hospital? What are the most common misunderstandings, the most frequent causes of complaints? What areas of hospital operation are most in need of community enlightenment and support?

The answers to such questions help to determine the hospital's public relations objectives in order of importance, and the objectives in turn give direction, help to develop a blueprint, for the public relations program as a whole and for its component activities.

When newspaper publicity is sought with due regard for news values and general propriety, there should be certainty that it will do much more than merely get the name of the hospital into print.

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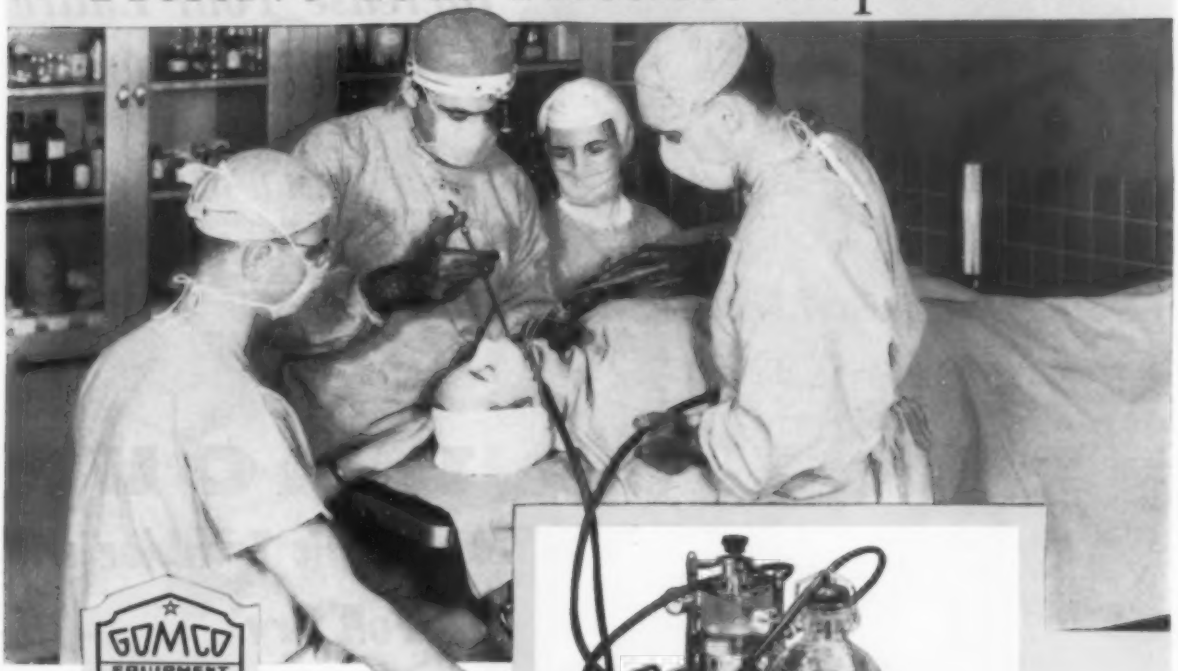

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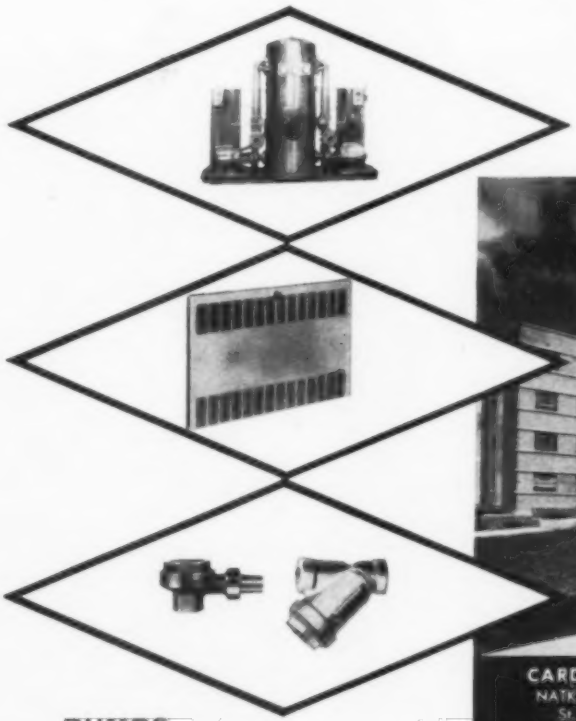

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Every day . . . Dunham-Bush "one source—one responsibility" . . . makes more sense to more people who specify and install heating equipment.

At the Cardinal Glennon Memorial Hospital for Children in St. Louis, for example, you'll find *all* pumps, *all* specialties, *all* convectors are by Dunham-Bush.

Let Dunham-Bush assist you in your heating plans. Write for details of our complete heating line.

America Looks to DUNHAM-BUSH *for Modern Heating*

DUNHAM-BUSH, INC.

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SALES OFFICES LOCATED IN PRINCIPAL CITIES

For additional information, use postcard facing Cover 3. 15

In Bombay, too, Pentothal serves

Advantages such as quick response . . . smooth, painless induction . . . and an uncomplicated, yet swift recovery help make Pentothal a favorite the world over in intravenous anesthesia. Add to this, the fact that there are now over 3000 published reports on Pentothal and you'll know some of the reasons why it is the world's most widely used intravenous anesthetic. Abbott

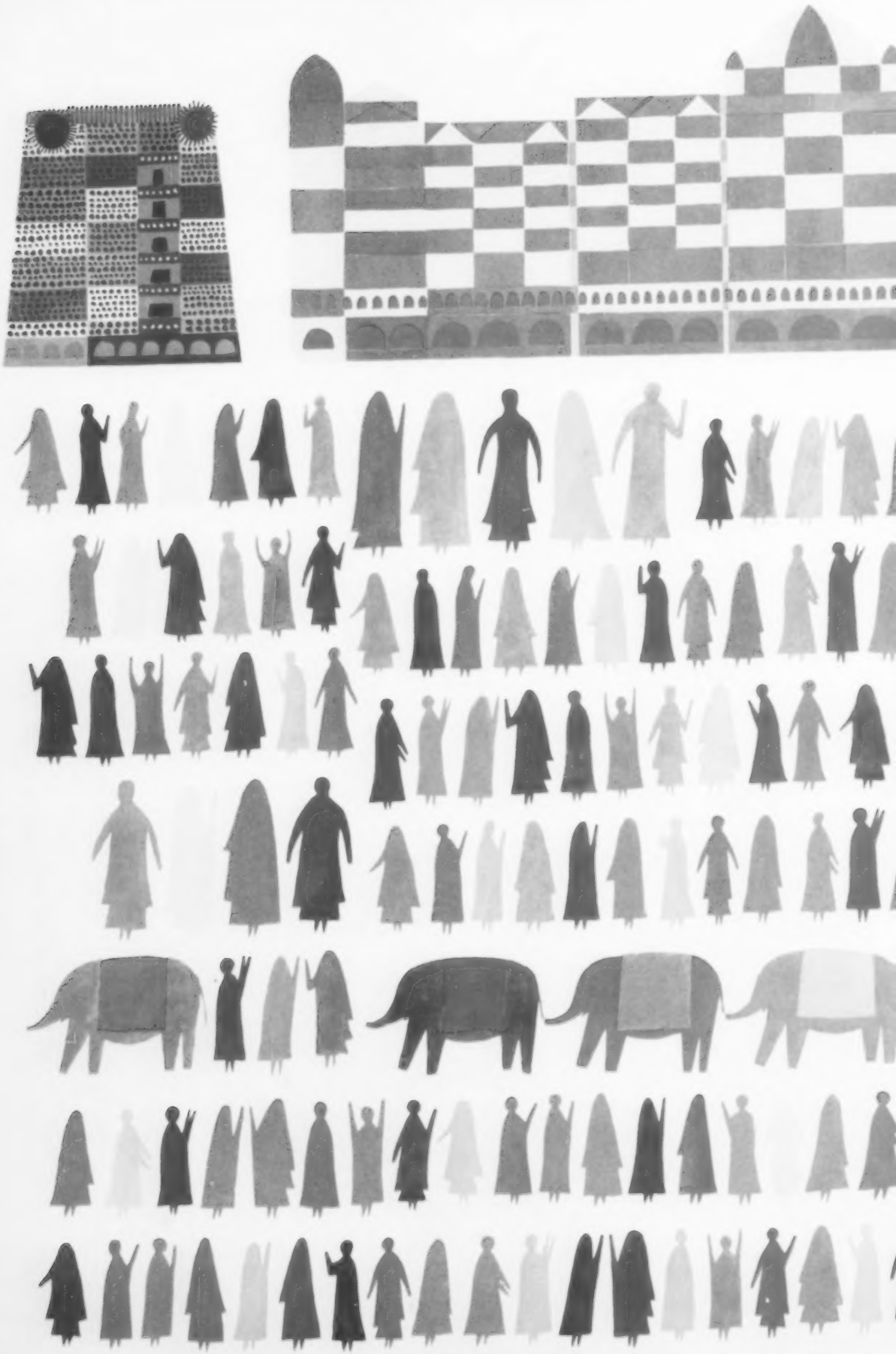
PENTOTHAL® SODIUM

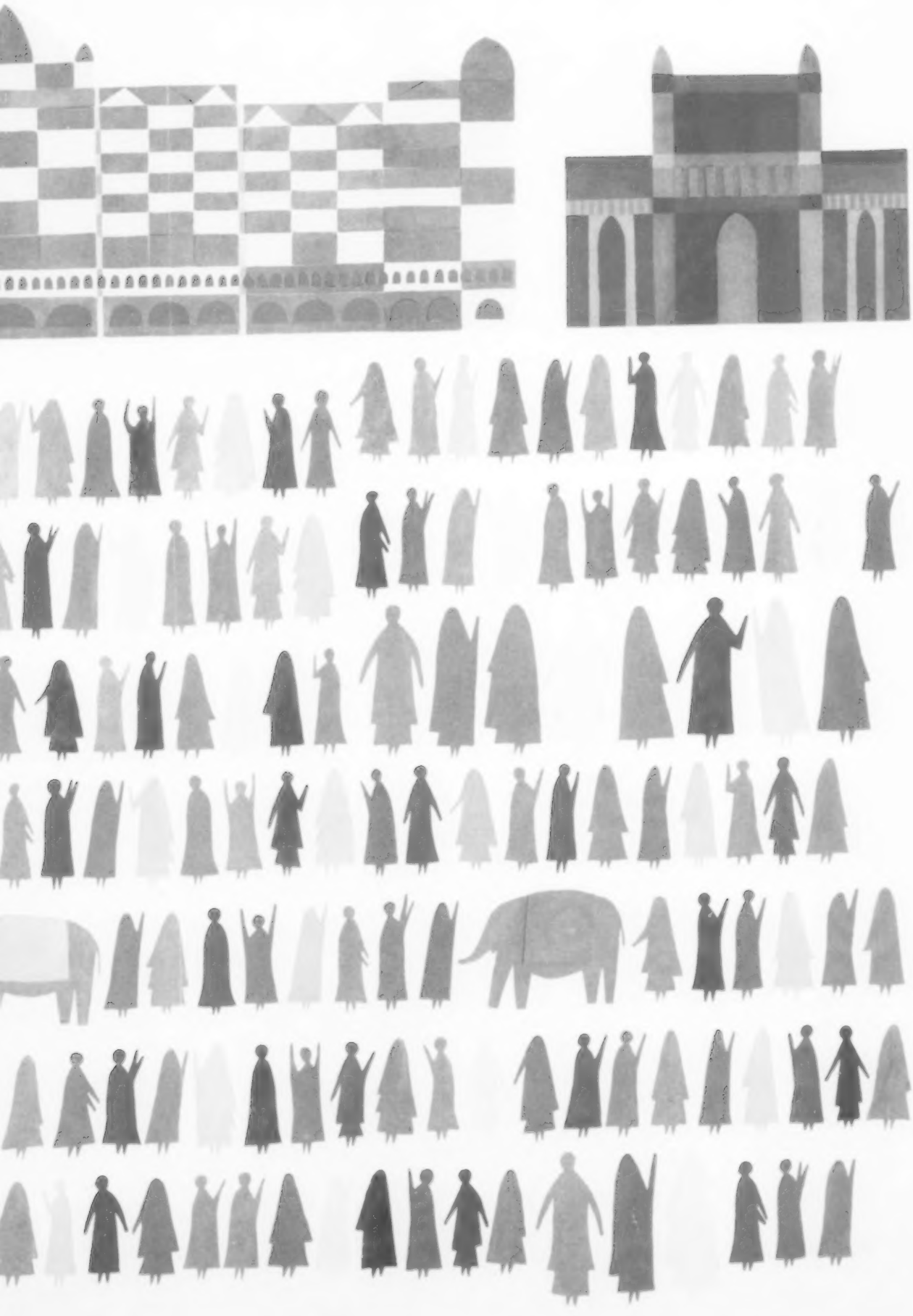
(Thiopental Sodium for Injection, Abbott)

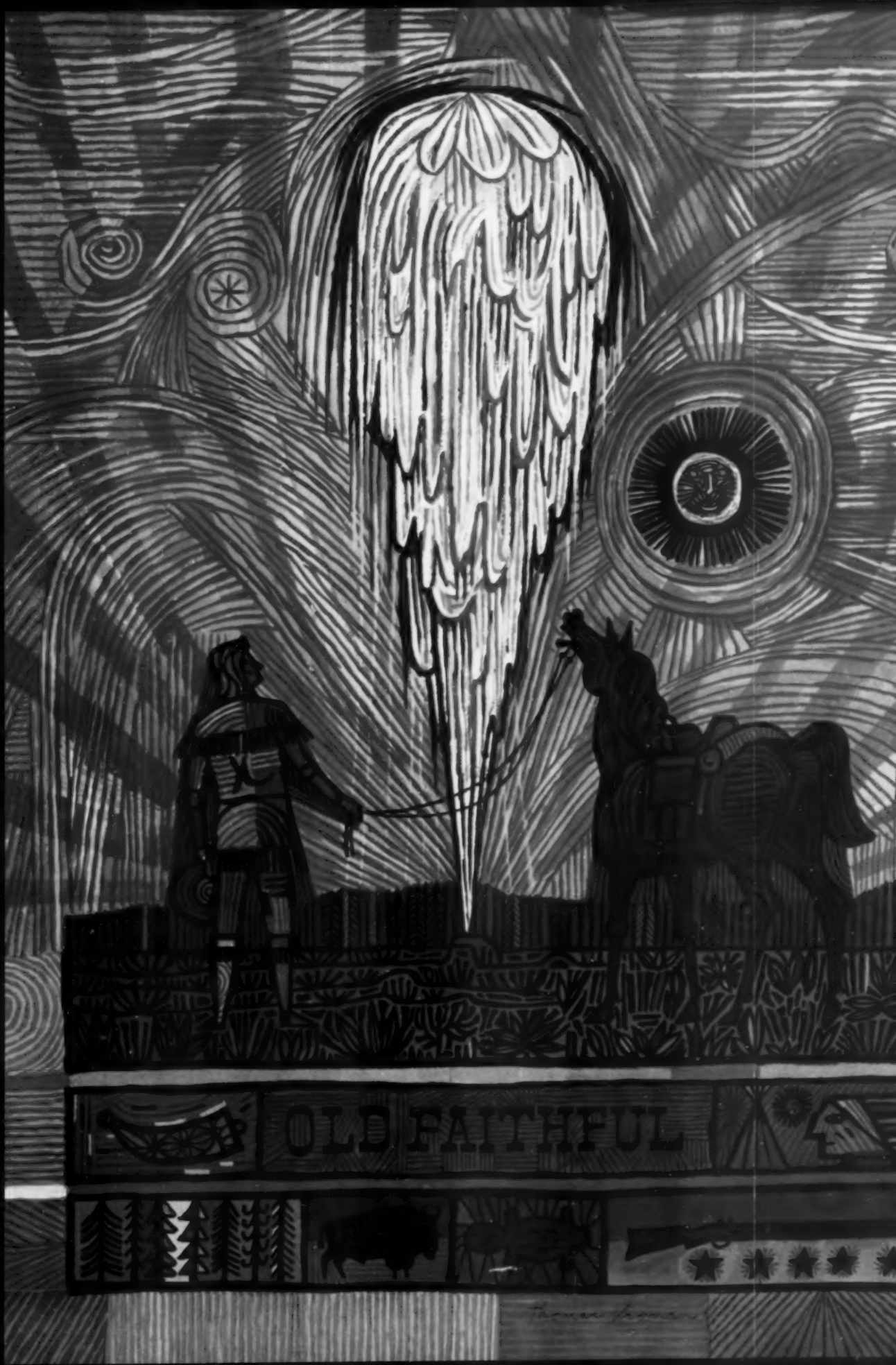
Pentothal—
the intravenous anesthetic
used in
more than 75 countries
of the world

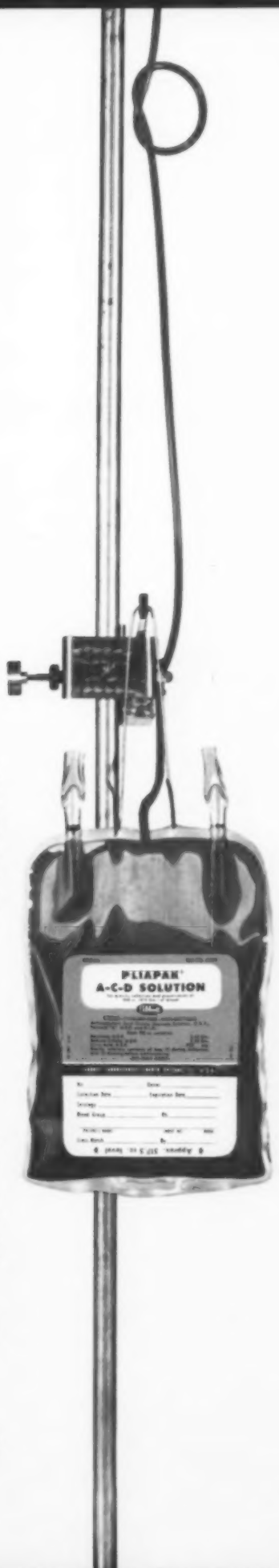
For a reprint suitable for framing of Emil Antonucci's painting, "Bombay" (opposite page), write: Professional Services, Abbott Laboratories, North Chicago, Illinois.

511170






OLD FAITHFUL



Ask for a demonstration of this newly improved PLIAPAK®. Try out its special convenience and versatility in collecting, storing, and giving blood.

Reliability in Action

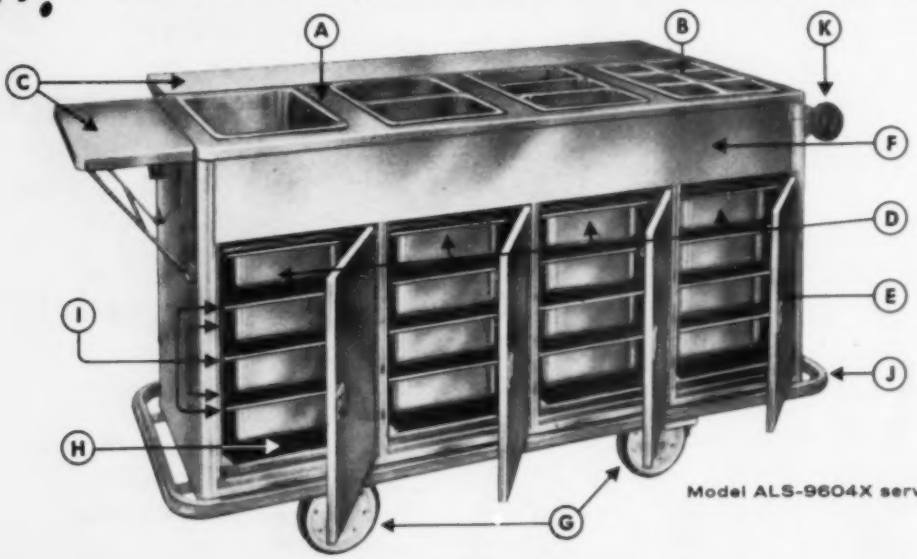
Which is the most practical system for handling blood: gravity container or vacuum? siliconed or plain? glass or plastic? Abbott provides them all, and each offers certain benefits of its own. Your Abbott man will gladly answer questions, and help set up the most advantageous system for *your* hospital. Talk to him . . . soon.

Abbott Parenterals

SOLUTIONS AND EQUIPMENT

For a handsome, wide-margin print of this Tom Vroman painting, showing Jim Bridger discovering Old Faithful, write Professional Services, Abbott, North Chicago, Illinois.

New! Institutional Bulk Feeder Serves up to 300 Meals per Load!



Model ALS-9604X serves 300

Check these features...each gives you important benefits!

Model ALS-7203X serves 200

Model ALS-4802X serves 125

A **TOP DECK OF HEAVY GAUGE STAINLESS STEEL,** one-piece *seamless construction* with all *edges rounded* and all interior corners of wells coved. Eliminates knife scraping. Smooth surfaces are easily cleaned.

B **FLEXIBLE TOP DECK** accepts full complement of square and rectangular, interchangeable insets, up to 6" deep*—lets you choose the top deck arrangement you need.

C **DROP-TYPE STAINLESS STEEL SHELVES** for convenient, easy tray assembly on large "counter" areas. Fold neatly when not in use.

D **LOWER STORAGE COMPARTMENTS ELECTRICALLY HEATED** and operated by toggle switch and pilot light on control panel. One compartment left unheated for greater versatility. Each compartment accepts 12" x 20" pans, up to 6" deep.

E **COMPARTMENTS ARE FITTED WITH DOUBLE WALLED, INSULATED DOORS,** hung on continuous piano hinges, spring actuated, with finger-tip release latches.

F **TOP DECK HEATED WITH HI-FLO THERMOSTATICALLY CONTROLLED HEATERS** for quicker, more uniform heating.

G **FOUR STAINLESS STEEL RUBBER TIRED, BALL-BEARING EQUIPPED 8" CASTERS** (2 stationary and 2 swivel-type)—provide quiet, easy maneuverability, and maximum durability.

H **EXCLUSIVE BLICKMAN COVED CORNER CONSTRUCTION THROUGHOUT**—provides a smooth coved interior surface for easy cleaning.

I **STURDY REMOVABLE STAINLESS STEEL PAN RACKS.** Racks come out easily (no tools) leaving smooth interior for quick, easy cleaning. Pan slides are set to accommodate up to 6" deep pans.*

J **REPLACEABLE CONTINUOUS RUBBER BUMPER** is set in heavy stainless steel channel, fully encircling the conveyor—gives greater impact protection. Will not mar walls.

K **STAINLESS STEEL PUSH HANDLES** mounted on stainless steel brackets, and protected by large donut type rubber bumpers—gives greater impact protection. Will not mar walls.

*Insets and pans available at extra cost.

Approved by National Sanitation Foundation

Now being used in large public institutions. Bulk feeder line consists of three standard capacities to suit your needs: 300, 200 or 125 meals. Or Blickman can build to meet specific requirements. For name and address of representative in your area and full information, write S. Blickman, Inc., 1511 Gregory Avenue, Weehawken, New Jersey.

Blickman-Built

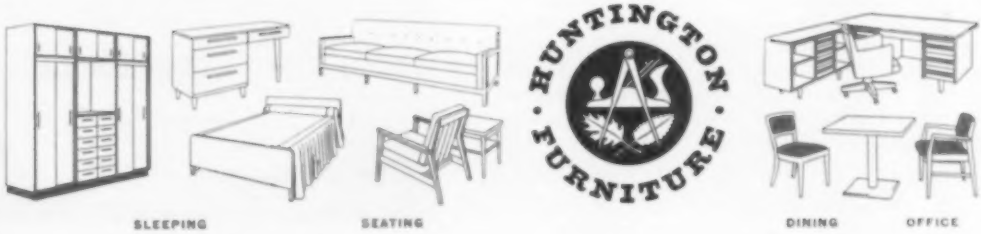
Look for this symbol of quality

BLICKMAN
FOOD SERVICE EQUIPMENT

HUNTINGTON

Designs by Jorgen Hansen and Jens Thuesen

SENSIBLE...COMFORTABLE...DURABLE



All HUNTINGTON patterns have clean tailored lines. Cases and tables have plastic tops. Finishing materials are baked on, resulting in a stain resistant finish that requires a minimum of maintenance. Select your furniture from HUNTINGTON's extensive group of patterns for every purpose.

Send me complete information MH 11-58

Name_____

Company_____

City_____

Attach to your letterhead and mail to: HUNTINGTON FURNITURE CORPORATION, Huntington, W. Virginia.

For additional information, use postcard facing Cover 3. 23

General Electric's x-ray representatives are trained consultants whose sense of responsibility to you goes far beyond sales alone. Here, four of these men report on the G-E diagnostic line to help you...

Choose your

THE IMPERIAL

"It's a pleasure to work with the radiologist who's ready to own an Imperial," reports W. M. Ross, Atlanta, Ga. "You sort of share a milestone with him . . . know you're outfitting him with our *finest* diagnostic unit. My customers are most impressed by Imperial's deluxe automatic spot-film device and phototimer and unusual 180° ring-rotated table. These and other features seem to fulfill the radiologist's desire for equipment that behaves like an extension of himself. And the Imperial makes it possible for me to fully equip doctors who are limited by small 12-foot examining rooms. What's more, I know my Imperial owners get satisfaction from our G-E nameplate. Everyone recognizes this symbol of quality — laymen and professionals alike."

THE REGENT

"Many I talk to describe the Regent as the backbone of their x-ray department," explains R. D. Newell, Providence, R. I. "It's really amazing how this one stands the gaff of hard use, day-in, day-out. My installations show a consistent history of solid performance with little attention. My radiologist friends like the smooth, adjustable-speed angulation through 45° Trendelenburg . . . the obstruction-free design . . . Regent's convenience for consultations and resident training. What does it take to interest a radiologist in a Regent? Just the chance to try one, I find."

Your own G-E x-ray representative stands ready to give you helpful information on all these fine General Electric products. Talk to him soon. Or you can obtain illustrated literature by writing X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, Room H-111.

partner...

THE ARISTOCRAT

"I call the Aristocrat a *lot* of x-ray equipment for the price," says J. W. Heller, Topeka, Kan. "I often recommend its economy for both private and hospital practice — who can match it? Full diagnostic range... 15° Trendelenburg table... overhead tube hanger... automatic spot-film device... sealed spot-film phototimer. Aristocrat has the features radiologists need! They like the full-size table too... aren't forced to shove patients into freak positions. Of course, they also appreciate the backing of traditional General Electric cooperation when they need to call on us."

THE PATRICIAN

"The Patrician's low cost comes as a big surprise to many radiologists," says T. B. Moore, El Paso, Texas. "... Makes it easy for me to fit a new G-E unit into the most modest budget. And here's a natural where hospitals want to increase patient-handling capacity. Just as low-cost autos encouraged two-car families, the Patrician makes it really practical to add an extra x-ray unit. Look at what it offers — full-size table . . . independent tube stand . . . rotating anode tube . . . fluoroscopic screen or spot-film unit. With 200-ma power, it can be purchased at a price that makes it foolish to settle for less!"

Progress Is Our Most Important Product

GENERAL ELECTRIC

For additional information, use postcard facing Cover 3.

the question is only in her mind. She isn't really worried. But she wonders, sometimes, if those dishwashers downstairs might slip-up, and fail to get every single one of those dishes really hospital clean. Back home, it's happened to her more than once.

OVER 275 HOSPITALS NOW USE D

for every food and beverage service in attractive "Floral" design. l

not all paper cups are DIXIE C

*DIXIE IS A REGISTERED TRADE MARK OF DIXIE CUP DIVISION OF AMERICAN CAN COMPANY

the answer really made her smile. She'd never stopped to think . . . "Where else does it make more sense to use single-service Dixie Cups and Plates than in a hospital? There's no question about their cleanliness, and they're so attractive, too. What a wonderful idea."

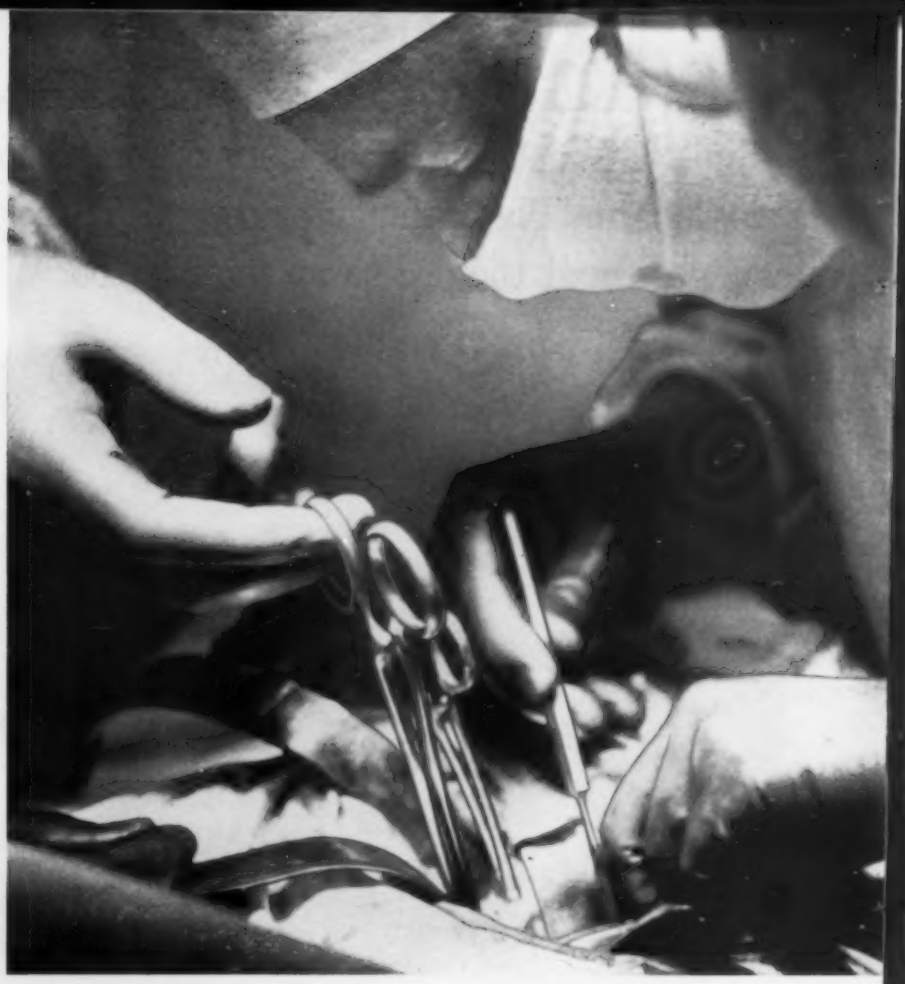
DIXIE* MATCHED FOOD SERVICE!

. . . lightens the load of overworked staffs—saves money in the kitchen, too.

CUPS . . . just the best ones!

DIXIE CUP DIVISION OF AMERICAN CAN COMPANY, EASTON, PA., CHICAGO, ILL., DARLINGTON, S. C., FT. SMITH, ARK., ANAHEIM, CALIF., LEXINGTON, KY., BRAMPTON, ONTARIO, CANADA.

don't let *any* hospital hands spread disease



USE

GERMA-MEDICA®

LIQUID SOAP WITH HEXACHLOROPHENE

Hands do the work in every hospital . . . and hands can carry disease. That's why *all* hospital hands . . . from chief surgeon to typist . . . should be clean and disease-free. Now Germa-Medica* Liquid Surgical Soap with Hexachlorophene makes this standard of cleanliness possible throughout the hospital.

Tests by an independent research laboratory prove a daily 3-minute wash using Germa-Medica*, diluted as much as 4:1, reduces bacteria in the area cleansed well below safe levels, produces a bacteriostatic condition that lasts for many hours. Yet highly-concentrated Germa-Medica* *costs only 1/5c a wash.* A fine soap made with imported olive oil and an effective emollient, Germa-Medica* with Hexachlorophene does not leave hands irritated or sensitized.

Help control the spread of communicable disease by using Germa-Medica* for hand washing everywhere in your hospital. Write today for a free sample. Test the remarkable germicidal action of Germa-Medica* Liquid Soap with hexachlorophene.

MAIL COUPON TODAY!

HUNTINGTON LABORATORIES, INC.
Huntington, Indiana

☐ Please send free sample of Germa-Medica* with Hexachlorophene and test*result booklet.

☐ Have your representative call.

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HUNTINGTON LABORATORIES
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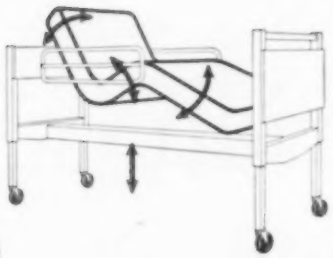
*Reg. U.S. Pat. Office

Only the

AMP ALL-ELECTRIC HOSPITAL BED

designed and manufactured by the American Metal Products Company of Detroit

offers all these advantages for the patient's comfort and the saving of nursing personnel's time



1 — 8 distinct motorizing actions — the entire bed is electrically operated, smoothly, quietly.

2 — Hand-held push-button control is instantly accessible for patients or nurses.

3 — Panel height of bed can be adjusted from 15" to 30", or a mattress height of 19½" to 34½".

4 — Central location of electrical mechanism provides full working clearance beneath bed.

5 — 3-piece, posture-firm mattress panels eliminate need for bed boards. Overall length of mattress surface 7 feet.

6 — Head, seat and foot sections are electrically, individually activated, merely by pushing a button.

7 — More medical positions can be obtained electrically with this bed than with any other electric bed.

8 — Construction of bed permits easy storage of side rails under mattress panel.

Fully automatic—convenient, movable, patient's hand control switch. Nurse controlled high-low switch at foot of bed.

Adjustment to low chair height assists patients in early ambulation.

Nursing personnel can conveniently tend to patients' needs, or make beds, without stooping or bending.

Side rails are quickly raised and securely held in place for patients' safety.

AMERICAN METAL PRODUCTS COMPANY

DETROIT 4 amp MICHIGAN

The same type of smooth and quiet electrical mechanism, designed and introduced by the American Metal Products Company for 4- and 6-way power automobile seat adjusters, is used thru-out this all-electric bed . . . a type of mechanism that has proved successful for 6 years . . . and is exclusive with this bed.

B.F.Goodrich

B.F. Goodrich announces the Sanitized Texfoam Mattress

Proved to inhibit the growth of antibiotic resistant Staphylococcus aureus*

Hospital mattresses have long been suspect as a potential source for supporting staphylococcal infection.

Previously, most hospitals had to depend on unpredictable and often unreliable methods of combating this problem. But now, the Sanitized® B.F. Goodrich Texfoam mattress offers you built-in protection against staphylococcal infections.

This bacteriostatic property was proved in tests using a staphylococcus aureus strain resistant to Penicillin, Erythromycin, Chloromycetin, Terramycin, Achromycin, Matromycin, Albamycin and Magnamycin. Within one hour the Sanitized B. F. Goodrich Texfoam mattress core was completely clear. And since every mattress requires covering, B. F. Goodrich also had a Sanitized ticking tested. This proved to be clear after 4 hours.

The B. F. Goodrich Texfoam hospital mattress is now available from your supplier. You can ask him for details or write us at the address below – but, remember *while every B. F. Goodrich Texfoam hospital mattress has this bacteriostatic property, all ticking does not* – you'll have to specify Sanitized ticking.

Complete test report is available from The B. F. Goodrich Company, 419 Derby Place, Shelton, Connecticut.

**Test by Foster D. Snell, Inc.*

B.F.Goodrich ***Texfoam mattresses***

NEW

Cross-Knit, a wonder soft, super absorbent towel, and a good-will builder in the washroom

Fort Howard Paper Company

Green Bay, Wisconsin

America's most complete line of paper towels, tissues and napkins

Hospital Management Men

Before you dismiss "office automation" as too costly and complex...read this!

Today, automation in the office is the subject of hot debate. To many hospital administrators and comptrollers it means a mass of complicated machinery and the highly-trained personnel to run it. To others, it means excessive training and indoctrination, an inordinate outlay of cash, an end to time-tested methods of operation.

Yet most hospital management men agree that today, in the face of ever-increasing costs, what they *need* are the faster, more accurate facts and figures that office automation can deliver – the up-to-the-minute facts and figures on revenue, patient days, service-department utilization that contribute so greatly to better patient care. But, they ask, how do we get them without undue cost and complexity?

The answer is with new Keysort machines and methods.

Why Keysort? Because Keysort, alone, is reducing the cost and complexities of modern office automation with a highly-flexible system that fits easily into your existing operations.

Result: Keysort is today cutting paper-work down to size.

Keysort procedures are so simple that they can be handled completely by your present staff. Basic data on Keysort Requisition-Charge Tickets is simultaneously notched and imprinted with the Keysort Data Punch for fast, easy classification. Complete and automatic processing is provided by the Keysort Tabulating Punch which punches, adds and totals quantities and amounts. Original records can now be processed automatically to produce desired reports – *on time.*

New Keysort machines and methods today offer you the simplest means of instituting the *practical* modern office automation which can speed to your desk the on-time reports that aid you in providing better patient care. With little or no change in your present methods. Without the need for specialized personnel. And at remarkably low cost.

Contact your nearby Royal McBee Data Processing Representative, or write Royal McBee Corporation, Hospital Division, Port Chester, N. Y. for illustrated Brochure S-442.

ROYAL McBEE · *data processing division*

NEW CONCEPTS IN PRACTICAL OFFICE AUTOMATION

the American

UTENSIL WASHER-SANITIZER

Protects patients and personnel against cross contamination - - dependably and at less cost.

Prevention of cross contamination from patient utensils is accomplished rapidly, automatically and at reduced cost with the new American Utensil Washer-Sanitizer. The powerful detergent wash, double rinse and steaming cycles are completed in 22½ minutes . . . with no attention from nursing personnel other than loading and unloading. Three sets of utensils are processed in two loads.

The American Utensil Washer-Sanitizer is economical to install and pleasant for nursing personnel to use. It assures uniformly high standards of cleaning and sanitizing by eliminating the possibility of human error . . . and, its modest cost is more than justified by the saving in personnel time alone.

The American Utensil Washer-Sanitizer is available with clean-up counter or as the free-standing unit shown above.

For complete information on this improved utensil technique, write for bulletin SC-321-R.

AMERICAN STERILIZER
ERIE • PENNSYLVANIA

World's Largest Designer and Manufacturer of Sterilizers, Surgical Tables, Lights and related hospital equipment

TO REDUCE the spread of staphylococci and other organisms in hospitals, handwashing is "...*possibly the most important single control measure.*"[1] Just soap-and-water cleansing "...does not go far enough because it cannot be relied upon to kill the staphylococci."[2] But "when pHisoHex is used by nurses for handwashing, it is not possible to recover Staphylococcus pyogenes from their hands."[3] In addition, bacterial resistance to hexachlorophene does not develop.[4]

At the National Institutes of Health, the incidence of hospital cross infection was practically eliminated when *all* hospital personnel washed with pHisoHex before and after caring for any patient.[5] Routine use of pHisoHex for bathing infants as well as for routine handwashing by hospital nurses has helped prevent staphylococcal epidemics among newborn infants.[6,7]

Why is* pHisoHex *so often preferred? "The preparation appears to kill bacteria quickly, inhibits their growth, renders the skin's *surface* virtually sterile in many cases, forms an antibacterial film which kills fresh bacteria in the event of subsequent contamination after its use, saves time.... It is nonirritating, and it is hypoallergic."[8]

against STAPHylococcal infections

with pHisoHex®

Antibacterial detergent with 3% hexachlorophene

1. Brown, J. W.: *J.A.M.A.* 116:1185, March 8, 1958. 2. Klarmann, E. G.: *Am. J. Pharm.* 129:42, Feb., 1957. 3. Hardyment, A. F.: Pediatric Clinics of North America, Philadelphia, W. B. Saunders Co., May, 1958, p. 287. 4. Gould, B. S.; Frigerio, N. A., and Hovanesian, J.: *Antibiotics & Chemother.* 7:457, Sept., 1957. 5. Benson, M. E.: *Am. J. Nursing* 57:1136, Sept., 1957. 6. Wysham, D. N., et al.: *New England J. Med.* 257:295, Aug. 15, 1957. 7. Agate, G. H.: *J. Mich. M. Soc.* 57:853, June, 1958. 8. Medrek, T. F., and Litsky, W.: *Surg. Gynec. & Obst.* (Internat. Abstr. Surg.) 104:209, March, 1957.

Reinforce the antiseptic umbrella with anti-staphylococcal Zephiran® chloride, a powerful antiseptic and germicide that is nonirritating to the skin and mucous membranes—and ***Roccal,®*** a solution for general hospital sanitization and disinfection. Roccal rinsing renders textiles actively bacteriostatic against respiratory and wound discharge.

Write for or ask the Winthrop man for the new leaflet, "Practical Pointers to Protect Your Hospital Against STAPHylococcal Infections."

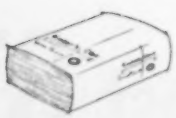
Winthrop LABORATORIES New York 18, N. Y.

pHisoHex, Zephiran (brand of benzalkonium as chloride, refined), and Roccal (brand of benzalkonium chloride, technical), trademarks reg. U. S. Pat. Off.

Your patients have a preference . . . make it yours!

KLEENEX TISSUES . . . soft, strong, absorbent—convenient necessity in prep rooms and in patients' rooms.

KLEENEX TABLE NAPKINS . . . for use in staff dining rooms and on patients' trays. Luxurious yet economical.



SANEK TOWELS . . . ideal for drying hands, for baby scale liners, tray mats, bibs, etc.

DELSEY BATHROOM TISSUE . . . wonderfully soft, like Kleenex tissues. Tears evenly, saves you money.

Kimberly Clark
SERVICE PRODUCTS

KLEENEX, DELSEY and SANEK are registered trademarks of KIMBERLY CLARK CORPORATION

Kimberly-Clark Corporation, Neenah, Wisconsin

NOW-*the*

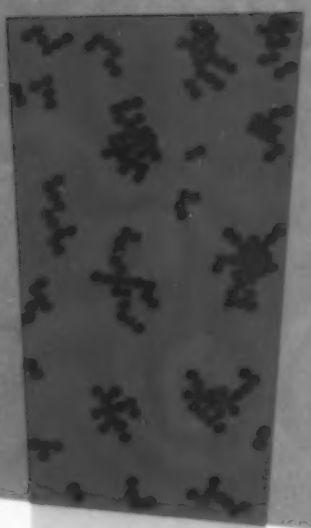
first-choice

antibiotic

for any

staph

infection



KANTREX

Kanamycin Sulfate

Clinically proven bactericidal antibiotic providing:

- ***Bactericidal*** **– not merely bacteriostatic – action**
- **Wide antimicrobial range…even against many heretofore resistant organisms**
- **Rapid effect**
- **High serum levels**

– "leaves the least for the host to do"

Bristol

For rapid bactericidal action in any staph infection...

KANTREX®

Kanamycin Sulfate

"The rapidity with which bacteria are killed by this agent (KANTREX) is reflected by the promptness of the clinical response."[11]

SUMMARY OF CLINICAL RESULTS WITH INTRAMUSCULAR KANTREX —

	NUMBER OF PATIENTS	GOOD RESULTS	FAIR RESULTS	POOR RESULTS OR RESISTANT TO KANTREX	NO RESPONSE OR DIED
Respiratory tract disease	77	59	6	4	12
Urinary tract disease	204	148	–	5	51
Soft tissue infections	177	153	5	4	15
Septicemia	20	10	2	1	9
Osteomyelitis	15	9	–	2	4
Bacterial endocarditis	8	4	2	–	2
Miscellaneous diseases	40	30	6	3	1

— IN 559 CASES REPORTED BY 31 INVESTIGATORS

Indications: Indications for KANTREX include infections due to kanamycin-susceptible organisms, even many of those resistant to other antibiotics:

Respiratory tract infections: Tracheitis, bronchitis, pneumonitis, bronchopneumonia, lung abscess, pleuritis, empyema, and bronchiectasis.

Urinary tract infections: Acute and chronic pyelonephritis, and cystitis.

Soft tissue infections: Wound infections, abscesses, cellulitis.

Blood stream infections.

Osteomyelitis.

Dosage: Adults: Average daily intramuscular dose 1 to 2 Gm. in 2 to 4 equally divided doses.

Children: Average daily intramuscular dose 15 to 30 mg. per Kg. in 2 to 4 equally divided doses.

Precaution:

Skin eruptions and signs of renal irritation (which disappeared on cessation of therapy) have been occasionally noted. In a few cases, signs of eighth nerve dysfunction (tinnitus, vertigo, loss of hearing) have been observed: (1) in patients with pre-existing renal insufficiency, (2) in patients receiving 18 Gm. or more of KANTREX, and (3) in patients over 45 years of age. Animal studies indicate that KANTREX has less auditory toxic potential than dihydrostreptomycin.

Supply: Available in rubber-capped vials as a ready-to-use sterile aqueous solution in two concentrations (stable at room temperature indefinitely):

KANTREX (kanamycin sulfate) 0.5 Gm. in 2 ml. volume.

KANTREX (kanamycin sulfate) 1.0 Gm. in 3 ml. volume.

Kantrex Sensitivity Discs and comprehensive literature available on request.

References: 1. Bunn, P., Baltch, A., and Krajnyak, O., State University of New York Upstate Medical School, Syracuse, N.Y.: Annals N.Y. Acad. Sci. In press. 2. Cronk, G. A., and Naumann, D. E., Dept. of Health and Preventive Medicine, Syracuse University, Syracuse, N. Y. *Ibid.* 3. Davies, F. G., Marcy State Hospital, Marcy, N.Y. *Ibid.* 4. Dube, A. H., Edward S. Van Duyn Memorial County Hospital, Onondaga, N.Y. *Ibid.* 5. Finegold, S. M., Winfield, M. E., Aronsohn, R. B., Hewitt, W. L., and Guze, L. B., University of California Medical School, Los Angeles, Calif. *Ibid.* 6. Greey, P. H., and Wightman, K. J. R., University of Toronto, Toronto, Can. *Ibid.* 7. Herrold, R. D., and Karabatsos, N., College of Medicine, University of Illinois, Chicago. *Ibid.* 8. High, R. H., Sarria, A., and Huang, N. N., Temple University School of Medicine, Philadelphia. *Ibid.* 9. Ichikawa, T., Medical Faculty, University of Tokyo, Tokyo, Japan. *Ibid.* 10. Katz, S., District of Columbia General Hospital, Washington, D.C.: Personal communication. 11. Rutenburg, A. M., Kootz, G. M., and Schweinburg, F. B., Harvard Medical School, Boston: Annals N.Y. Acad. Sci. In press. 12. Ruiz Sanchez, F., and Ruiz Sanchez, A., University of Guadalajara, Jalisco, Mexico. *Ibid.* 13. White, A., and Knight, V., School of Medicine, Vanderbilt University, Nashville, Tenn. *Ibid.* 14. Yow, E. M., and Monson, O. T., Baylor University College of Medicine, Houston, Tex. *Ibid.* 15. Yow, M. E., and Womack, G. K., Baylor University College of Medicine, Houston, Tex. *Ibid.*

Bristol LABORATORIES INC.
SYRACUSE, NEW YORK

News Bulletin

Volume I ECONOMICS LABORATORY, INC. 250 Park Ave., New York 17

GREATEST BREAK-THROUGH IN DISHWASHING CHEMISTRY

★ ★ ★ ★ ★

Wash Pressure Now Chemically Controlled

SCORE* and EVENT* Called Biggest Development Since Introduction Of Polyphosphates

Detergents are exclusive products of Economics Laboratory

SCORE and EVENT are chemical formulas developed by Economics Laboratory to maintain constant wash pressure in dishwashing machines—this means now for the first time a dishwashing machine can be operated close to its maximum efficiency.

Until recently no one really knew what went on inside a dishwashing machine. Chemists at Economics Laboratory found out.

A dishwashing machine in good operating condition with only clean hot water will remove a great part of the gross food soil. Final removal of soil must be accomplished through the use of a good detergent at the right concentration.

However, as food soil is added to the wash water during the washing period, the less effective the machine becomes because wash pressure is reduced.

This drop in pressure was commonly thought to be due to poor pump action or clogged wash arms, but wash pressure problems are not confined to these mechanical defects.

Economics Laboratory chemists discovered that an "aerated solution"—a wash solution with many small air bubbles in it—can be just as serious as these mechanical defects. As a result of foaming or "aeration", the ability of a dishwashing machine to remove gross soil can drop 40 to 50 per cent. This "aeration" is difficult to detect by the operator.

This is what SCORE and EVENT do. They control "aeration" and foaming. SCORE and EVENT solve the problem of depressed wash pressure. *These* exclusive new detergents and only these, *control wash pressure chemically*.

SCORE* and EVENT* cut operating costs

SCORE and EVENT have qualities not found in ordinary detergents:

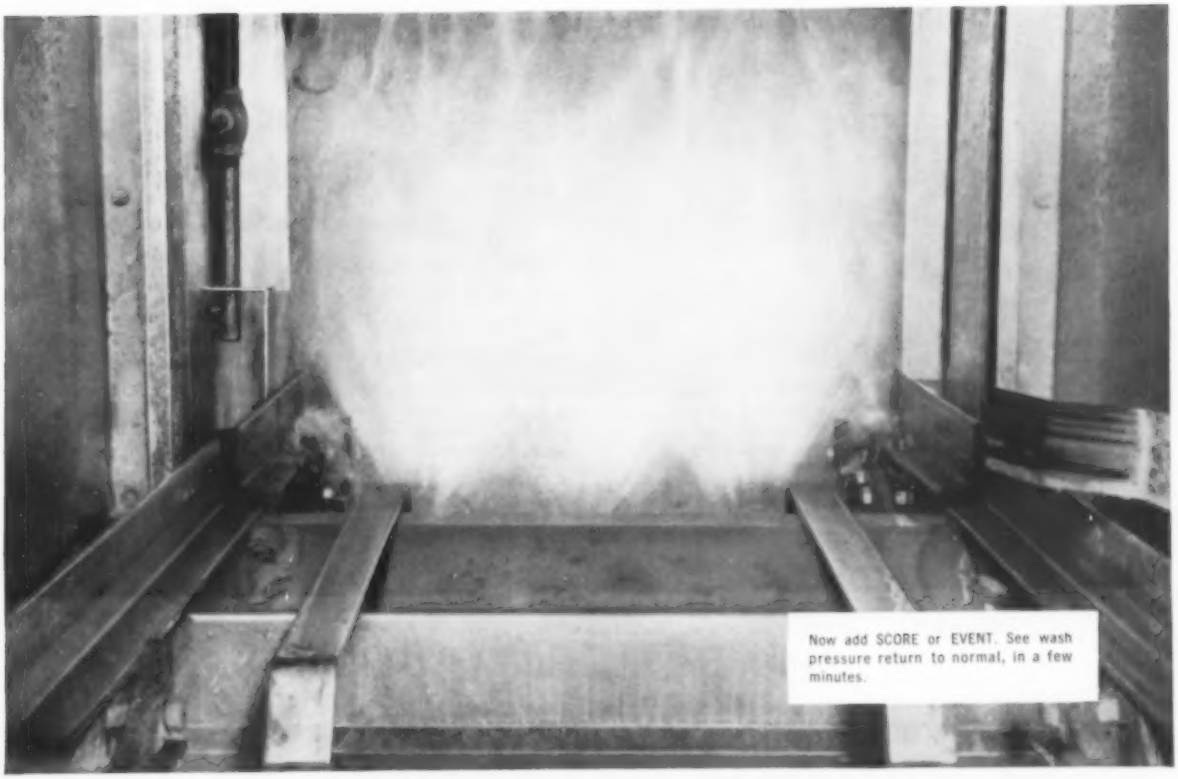
1. A unique ability to maintain normal wash pressure under various soil and operating conditions.
2. Allow machines to run close to maximum efficiency at all times.
3. Enable more rapid drying.
4. Eliminate or minimize spotting and streaking.

The result is maximum dishwashing efficiency at lower operating costs.

*Patents pending.

TRY THIS SIMPLE VISUAL TEST YOURSELF...

Make this simple visual test. Fill a dish-washing machine with hot water and an ordinary detergent. Start machine and allow to run for 3 to 5 minutes. Throw in ONLY one egg (or cup of powdered milk). See what ONLY one egg will do. Wash pressure falls off drastically.



Now add SCORE or EVENT. See wash pressure return to normal, in a few minutes.

Proteins Major Cause of Aeration or Foaming

Foam and aeration of wash solution can cause tremendous loss of wash pressure and cleaning action in dishwashing machines.

Fats have been commonly thought to be the most serious cause of aeration or foaming, but chemists at Economics Laboratory found that other food soils, especially proteins—eggs, meat, potatoes—are far more important than fats in causing wash pressure loss.

If you serve eggs, meat or mashed potatoes—milk and flour gravies too—your dishwashing machine will not operate at normal efficiency with ordinary detergents.

SCORE and EVENT have been specifically developed by Economics Laboratory to maintain the normal wash pressure in dishwashing machines under various soil and operating conditions. They eliminate aeration or foaming caused by food soils from proteins or fats.

SCORE* and EVENT* Scientifically Developed

EXCLUSIVE WITH ECONOMICS LABORATORY

SCORE and EVENT have been scientifically developed and thoroughly tested by experts in the laboratory and in the field.

SCORE is a heavy duty detergent, for medium to hard water areas containing metal-protective properties.

EVENT is a highly alkaline detergent for soft to medium water hardness areas and high-speed cleaning operations.

*Patents pending.

FREE! —Write in today for new informative booklet, "A Chemical Approach To Controlled Wash Pressure."

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Gentlemen:

I am interested in this new chemical discovery.

Please have one of your dishwashing engineers call to give me more information and an on-the-spot demonstration.

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RESULT... **complete blade protection** — maximum sharpness of these traditionally superior **carbon** steel blades assured

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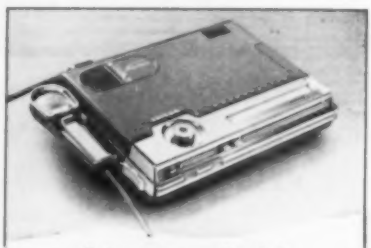

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new... a handy dispenser-cap which eliminates irritating searches for errant bottle caps.

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FLOOR MACHINE

Here's another MULTI-CLEAN engineering triumph . . . a complete new line of the world's *most modern* Floor Machines. Sleek . . . elegant . . . rugged . . . and champions in performance.

Beneath their graceful styling, these exciting and versatile new models offer mechanical features which are not available in any other machines on the market today.

Before you buy a floor machine for polishing, scrubbing, dry cleaning, waxing, buffing, sanding, grinding, or trowelling, it will pay you to investigate the savings and other advantages you will enjoy when you own a MULTI-CLEAN.

- Heavy-duty, gray, non-marking 3-conductor cable is detachable.
- Cable plugs into recessed receptacle in handle. No "pigtail."
- Handles have comfort grips; tapered back at natural, non-tiring angle for operator.
- Dual, independent acting switch levers give finger-tip control with *either* hand.
- 4-blade knife-type switch contains *more copper* than any other floor machine switch we know of . . . therefore switch failure is a rare occurrence.
- Handle "floats" or locks in any position from upright to horizontal. Regardless of handle position, the machine stays in perfect balance.
- Large stationary wheels make it easy to move from place to place, up and down stairs, over sills, etc. Axle supported at 4 points for maximum strength.
- Heavy, non-marking plastic bumpers completely encircle both base and top.
- Special hand grips at front and rear facilitate carrying when necessary.
- Capacitor-start, induction-run motor. Twin capacitors provide maximum starting torque with minimum current. Reaches full operating speed almost instantly.
- *All ball bearinged* gear unit is designed and manufactured exclusively by MULTI-CLEAN for this purpose. 12 gear teeth in mesh at all times. Quiet, factory sealed, and lubricated.
- Can be converted into efficient scrubbing machine by addition of solution tank, controls, and channel feed brush.

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For full details on MULTI-CLEAN Floor and Scrubbing Machines, call your local MULTI-CLEAN Distributor or write to MULTI-CLEAN Products, Inc., Dept. MH-63-118 St. Paul 16, Minnesota.

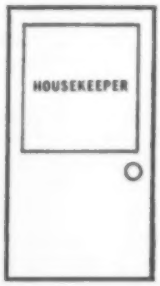
MULTI-CLEAN® Method

Sufficient detergency to satisfy the Housekeeper, efficient disinfection to satisfy the Professional Staff, lighter labor costs to satisfy the Administrator, and minimum costs of best supplies to satisfy you – Tergisyl offers all.

Better control of cross infection through simplified procedures is possible with the one-step Tergisyl method of disinfecting and cleaning. Reservoirs of staph, other common pathogens, and TB bacilli are destroyed routinely, efficiently with less effort.

For every 100,000 square feet of floor space in your hospital now cleaned and then disinfected by man-and-mop-and-pail, you can save as much as 5 man days per week, or 40 man hours, by adopting the one-step Tergisyl method.

Complete twice the work in half the time – and save money on both labor and materials. One-step Tergisyl cleaning procedure – which includes dependable disinfection – is quickly accepted, easier to follow.



Lehn & Fink's new weapon to combat cross infection

Best defense against spread of staph is careful attention to total environmental asepsis, including floors. With the Tergisyl method, efficient general disinfection is simultaneous with routine cleaning.

Tergisyl™

DETERGENT–DISINFECTANT

Cuts labor cost 47%

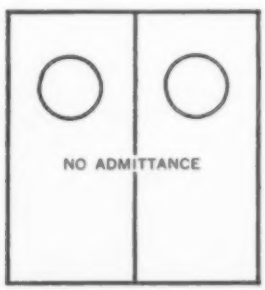
(by mop-and-pail method)

Cuts labor cost 22%

(by machine scrubbing-vacuum method)

Cuts material cost 5% to 10%

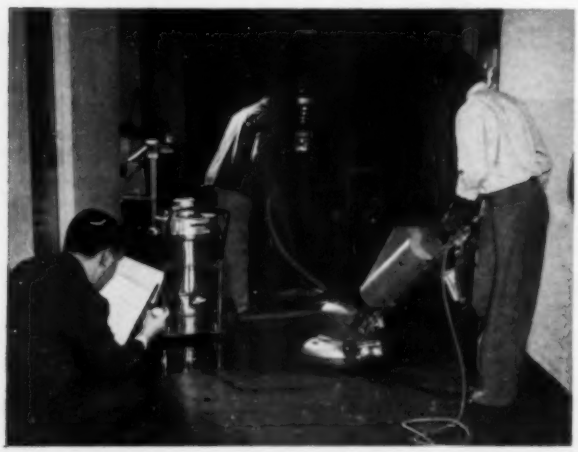
(using either of above cleaning-disinfecting methods)



Keeping the O.R. "clean" in every sense of the word is easier, quicker with the new Tergisyl technic. Efficient disinfection and dependable detergency are combined in one cleaning step to achieve environmental asepsis you can be proud of. Has no effect on conductivity.

For details of comparative time studies under actual hospital conditions— TURN PAGE

Comparative time studies of Tergisyl vs. conventional method washing and disinfecting using mop-and-pail technics. One-step Tergisyl method reduced the man-time required by 47%. Actual time saved was approximately 25 minutes per 1,000 square feet of floor area—a labor saving of 125 man hours or 15 man days per week in a 300-bed hospital.



Comparative time studies of Tergisyl vs. conventional machine scrubbing vacuum pickup, and mop-and-pail application of disinfectant. One-step Tergisyl method reduced the man-time required by 22%. Actual time saved was approximately 23 minutes per 1,000 square feet of floor area—a labor saving of 20 man hours or 2½ man days each week in areas of heavy soil in a 300-bed hospital.

Comparative cleaning and disinfecting efficiency of Tergisyl vs. conventional method. Subsequent inspection showed greater cleaning ability for Tergisyl than the detergent previously judged acceptable by the hospital. "Before" and "after" bacteriological tests confirm germicidal efficiency of Tergisyl.

Three years of research backed by over sixty years of experience have produced Tergisyl , detergent-disinfectant

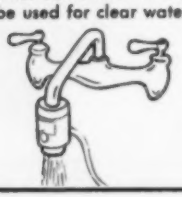
Since control of cross infection, especially from Staph, has become a major problem for hospitals, Lehn & Fink has felt an increasing responsibility to do everything possible to aid in this fight. Producing the most efficient disinfectants for hospital use has been our chief concern for many years. In addition, we have tried to supply these disinfectants in as practical and easy-to-use a form as possible so that the hospital could devote its attention to actual medical and surgical care of the patient.

Seriousness of the Staph problem has now made more adequate and dependable disinfection a necessary part of patient care. Development of Tergisyl, combining the comprehensive bactericidal, fungicidal, tuberculocidal efficiency you have come to expect of our products with sufficient detergency to clean even heavy soil satisfactorily, took many years of research. An independent research organization has confirmed our findings under actual hospital conditions.* But the most convincing test of Tergisyl's labor-saving advantages is use in your own hospital. We hope you will try it. Why not write immediately for your free sample and literature?

*Details of report available on request.

For metered mixing of Tergisyl and water in the proper proportions directly from the faucet—Use the L&F ECONOMIX™ PROPORTIONER

No more mixing and measuring. With the press of a button, the right proportion of Tergisyl is automatically released with the cleaning water. A carefully designed, stainless steel attachment which saves time, assures efficient use dilution every time. Same faucet can still be used for clear water.



Write for Tergisyl brochure and additional information about the convenient Economix.

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- for high or low installation
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Single "NXFI" unit with toggle switch at top, name plate at bottom. Switch and plate are easily interchangeable to accommodate different heights for varying reading level. Drip tray is available as an accessory for wet film viewing.

APPLETON "NXFI" Film Illuminator

(for non-hazardous areas)

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■ **The new APPLETON "NXFI" Film Illuminator combines high quality, light weight, and full x-ray view design with built-in flexibility that permits flush or surface mounting and choice of high or low switch position.**

All viewing with this unusual film illuminator is under strong, shadowless, full panel illumination. Ganged units may be operated separately. Relamping requires only the removal of two screws and plexiglass viewing panel. Truly this is the ideal hospital film illuminator where flexibility, even portability, is important and low initial cost must be considered. Full details on request.

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Units may be surface gang mounted. Chrome plated roller clips provided to hold film. Hinge clips also provided to suspend wet film.

Units may be flush mounted side by side or in banks of two at 5 ft. eye level or above according to requirements of any given area. Installation is simple . . . costs are low.

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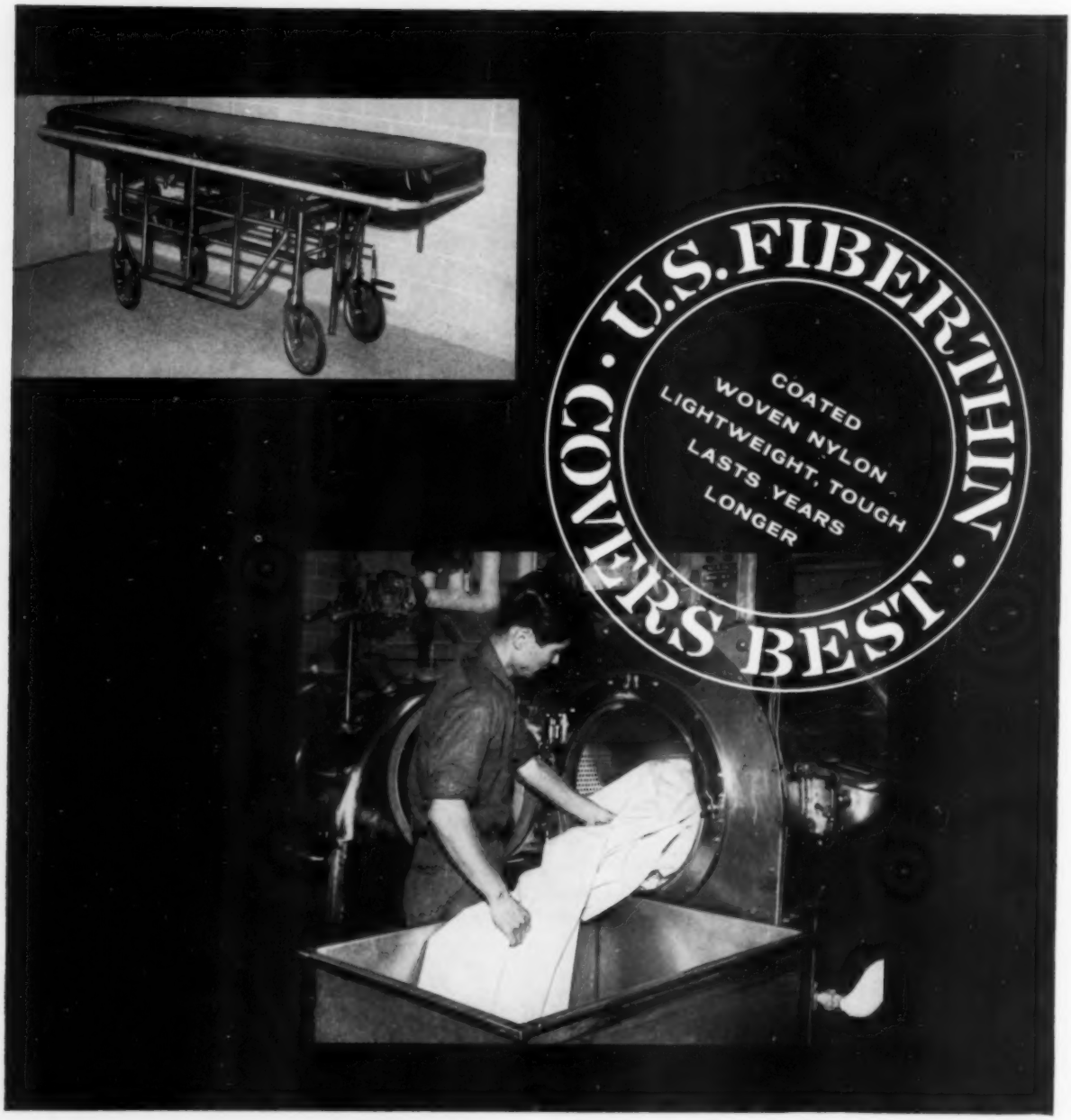

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Ask your supplier for U. S. Fiberthin—in rolls than can be cut to any size, or be made into fitted covers. For additional information, write United States Rubber, Mishawaka, Indiana.

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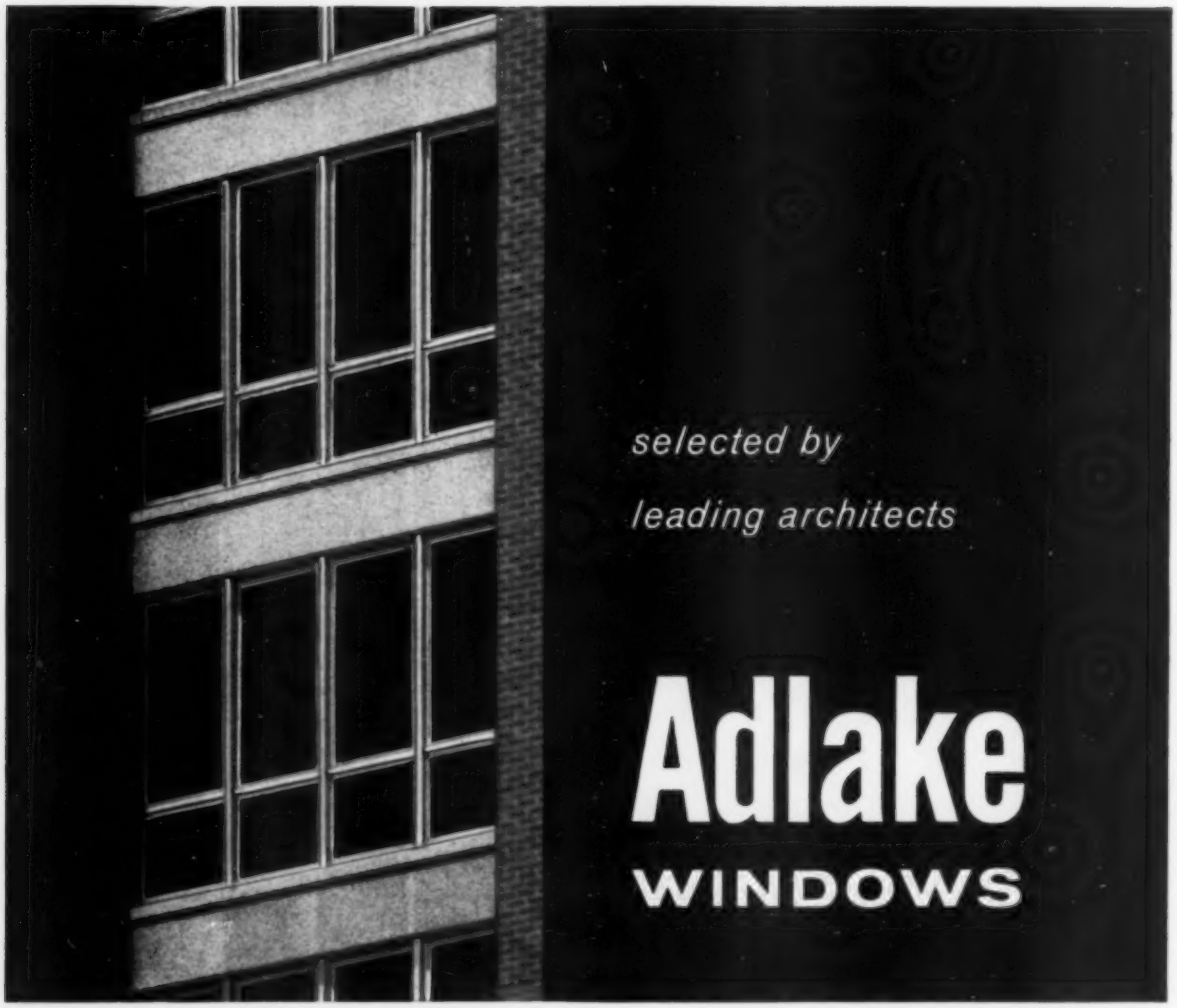

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SMALL HOSPITAL QUESTIONS

Hire Part-Time Nurses?

Question: To meet a continuing shortage of nursing personnel, we have hired several married nurses in the community who have families and are thus unable to work full time. Our director of nursing service is opposed to this practice and insists most hospital and nursing authorities consider it undesirable to employ nurses on a part-time basis. Is this correct?—T. S., Ga.

ANSWER: It may be undesirable, but it's increasingly necessary. According to a recent nationwide survey, approximately 25 per cent of general duty nurses employed in hospitals are serving on a part-time basis. These are either married women with families or students who are supporting themselves while taking advanced studies, it was reported. The number of part-time nurses working in hospitals is five times what it was 12 years ago, the report said.

Disaster Plan Is Needed

Question: In our small (25 bed) hospital we do not have a formal, written disaster or emergency plan. There are only six doctors working in the community and all of them are in close touch with the hospital, so we have felt a separate organization for emergency purposes is not needed. Recently, however, one of the doctors has been agitating for us to have a formal disaster plan, pointing out that other hospitals have such plans and this is now one of the requirements for hospital accreditation. Is this true? —A. K. G., Wyo.

ANSWER: Yes. Preparation of a written plan for organization of service and care of patients in disaster emergencies is considered essential by most hospital authorities and is required for accreditation by the Joint Commission on Accreditation of Hospitals. The doctor is right; even though all the physicians in the community are quickly available, there should be a plan for assignment of duties in an emergency, so time and effort will not be lost determining assignment of function, allocation of space, procurement of equipment and supplies and other details. Why not make the doctor who is "agitating" for a disaster plan chairman of a special committee assigned the responsibility of drawing up such a plan for approval of the others?

Value of Intensive Care

Question: We have read a great deal about intensive care units and have wondered whether it is worth while to think about establishing one of these units in a hospital of 100 beds. If we do this, how many beds should be included in the unit? How should it be staffed? Should we charge patients for the "extra" services rendered in this unit?—L. G. S., Neb.

ANSWER: Most hospital authorities agree today that it is possible to provide care for critically ill patients more efficiently when they are grouped in an intensive care unit that is especially staffed, equipped and supplied to furnish all the services needed in the care of critically ill patients. The number of beds to be set aside in such a unit may depend to some extent on the nature of medical practice in your hospital.

A good general rule-of-thumb is that at least 10 per cent of the total number of available beds should be in this area; thus in your case the unit might consist of 10 beds. The minimum staff at all times for the unit would consist of two or three registered nurses, or possibly two registered nurses and one practical nurse or aide.

An extra charge for service rendered during the time the patient is in the intensive care unit is customary; this may be $5 a day or $10 a day or more, depending on the nature of the case.

Under any circumstances, the unit should be planned and developed with the cooperation of the medical staff, working through the appropriate committee, or the chiefs of the various services. The hospital, nursing and clinical journals have published many articles on the operation of intensive care units, and these should be studied when the unit is being planned.

Should They Double Up?

Question: Occasionally in our small (30 bed) hospital it is necessary for us to ask employes to "double up" and do more than one job for limited periods. Recently, for example, we asked the administrator's secretary to learn how to run the switchboard so she could relieve the regular operator during her coffee break and lunch hour. The secretary seemed willing enough, but, later, we discovered other employes resented this as an imposition, saying, "She was hired to do one job and it isn't fair to make her do another. This is not in line with modern personnel practice." Are the employes justified in taking this attitude?—B. C., Ill.

ANSWER: Not unless the secretary or other employes are being loaded unreasonably with extra duties requiring overtime without pay and other substantive impositions. An employer has every right to make changes from time to time in an employe's "job content" or specific duties, and, in fact, in business and industry, where office workers are organized, this right is frequently recognized in union contracts. This is in line with modern personnel practice, and, moreover, the employer in this case should not feel obligated to increase the employe's salary simply because a reassignment of duties has occurred. Nevertheless, willingness to serve the employer in the most helpful way is certainly one of the factors to be considered when a pay increase is being determined.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

there's *EXTRA* safety

when the RIXSON *automatic* opens and closes the door

Whether the **RIXSON *automatic*** is actuated by mat (as illustrated), or by floor or wall switch, it offers many new advantages of safety and function. Busy hospital personnel with carts, trays or wheel stretchers need not stop to open doors, nor bother to close them.

The **RIXSON *automatic*** opens the door by hydraulic power and closes the door by hydraulic power—no springs required. It is completely concealed in the floor—no arms or other hardware are visible. And even the safety is automatic.

If a person steps on safety mat after door is in opening swing, door will not strike him, but will STOP.

If person is on safety mat, another person stepping on actuating mat will not cause door to swing open.

If a person walks off safety mat and then, while door is closing, steps back on mat, door will stop and not swing suddenly open.

A break-a-way that allows doors operating IN to be forced OUT in emergency (if there are no door stops) is standard equipment.

A safety trip prevents motor from running continuously and avoids danger of overheating.

Rixson engineers will gladly work with you on your original plans or special applications. Complete template and installation instructions furnished.

Write for complete description and details

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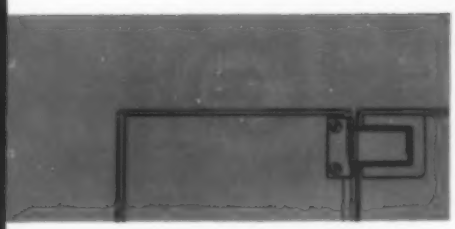
"WEIS WAS WISER!"

Architects, building owners and tenants become fully aware of WEIS toilet compartment advantages the second or third year after installation. That's when their original choice is confirmed, when they can say with firm conviction, "Our choice of WEIS was wiser!"



FLUSH UPPER HINGE—Newly designed so cover is flush with both faces of door. Door is supported both above and below hinge recess. Bearing is nylon, needs no lubrication.

CONCEALED LOWER HINGE—A gravity-type with nylon cams, this new Weistyle hinge never needs lubrication. Pintle is stainless steel.

DOUBLE-LOCKED CONSTRUCTION—Doors, stiles and partitions are now ingeniously double-joined to provide extra sturdiness and long trouble-free life.

WEIS *Vitre-Steel* toilet compartments have the features and construction advantages that make them the standard of comparison where extreme durability and long-lasting good appearance are important. Finished inside and out in vitreous porcelain enamel (fired, not baked), Weis compartments are not subject to breakage and staining. Nor do they present costly installation problems. Available in wide choice of colors . . . both floor-braced and ceiling-hung designs. See Sweet's Architectural File, No. 22b/We—or write for complete information.

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Weis Vitre-Steel compartments have been selected for prominent buildings designed by the following architects: McGuire & Shook, Indianapolis, Indiana; Wedemeyer & Hecker, St. Louis, Missouri; Raymond H. Weeks, Inc., Durham, North Carolina; Clyde Hufbauer, San Diego, California; Preston M. Geren, Fort Worth, Texas; Broad, Nelson & Corgan, Dallas, Texas; Mies Van de Rohe-Phillip Johnson-Kahn & Jacobs, New York.

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TOILET COMPARTMENTS

THE VAST MAJORITY OF THE NATION'S FINE BUILDINGS ARE SLOAN EQUIPPED

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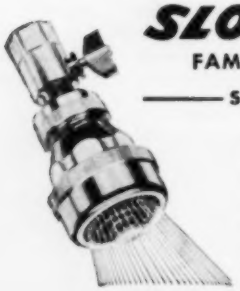
NEW FAME FOR 66-YEAR-OLD NAME

• A few months ago this new $25-million hospital was opened and assigned the honor of carrying forward the proud name, GRADY, its predecessor founded in 1892. This 21-story structure occupies an entire city block in downtown Atlanta, Ga. It contains 16 operating rooms, 10 delivery rooms and 22 emergency rooms. Facilities for more than 1,000 bed patients and accommodations for 150 resident physicians and interns are provided. Its out-patient clinic will have an ultimate capacity of 4,000 patients per day. Food service is provided by three cafeterias, and a kitchen capable of preparing 6,000 meals per day. In addition to instruction conducted by the Emory University School of Medicine, the Grady contains a School of Nursing, and the largest schools of Medical Technology and X-ray Technology in the Southeast. As are thousands of other expertly planned and skillfully erected buildings, the new Grady Memorial Hospital is equipped with SLOAN *Flush* VALVES, most favored of all for more than a half century.



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wire from Washington

AID FOR MEDICAL SCHOOLS

Prospects for passage of a bill to give federal help to medical schools and their related hospitals never looked better than they do right now.

When the new Congress moves into Washington in January, and looks about for some cause that will appeal to the people, it will find this a ready-made one.

No one opposes U.S. help to turn out more physicians, and those who have been pushing this legislation for years now find enthusiasm blossoming in places where there was only mild interest even as late as last session.

Latest all-out convert is Surgeon General Leroy Burney of Public Health Service.

Furthermore, Secretary Flemming, Burney's boss, has all but committed himself to go to the aid of the medical deans. In his latest gesture, Mr. Flemming announced he was appointing a committee to advise Public Health Service on medical education. At this writing the members haven't been named, but obviously the Secretary is prepared to back the committee's inevitable recommendation for immediate federal help.

Out of the movement, Dr. Burney is hoping that "reasonable and acceptable goals" can be reached in 10 years, which is not too distant a target date for the organization, financing, construction and staffing of new medical schools. The surgeon general also is expecting the committee to suggest the "proper role" for Public Health Service, and the next steps P.H.S. should take.

In an address to the American College of Surgeons, Dr. Burney made clear that he has left behind the idea of state and local responsibility for medical education, a theory so dear to those who oppose direct federal aid to the schools. He declared:

"The central imperative . . . is that the nation must plan and act as a nation in the development of health manpower. In the complex society of today, in a period of world crisis, health and educational services can no more be left to chance or exclusively to local initiative than can the development of heavy industry, consumer goods, transportation, public utilities and national defense."

This is the situation:

There is on the books now a law authorizing $30 million a year in grants to medical schools and other institutions — but for construction of research facilities only, not to build classrooms and teaching labs, not to pay salaries, not for overhead.

A feeble effort was made last session to liberalize this, but it failed for want of strong pressure on the outside. The Administration officially "supported" a broader law, but did almost nothing to get one passed, even at a time when a slight nudge might have put it over.

Now the Administration, judging from the strong stands of Mr. Flemming and Dr. Burney, will actively support a bill to help get more teaching facilities, and possibly to help pay salaries and overhead.

The American Medical Association, which has opposed some medical educational bills in the past as putting the federal government too deeply into the picture, now favors aid for teaching facilities, and one of its witnesses last year even said it had no objection to setting aside part of the grant for "overhead," which could mean salaries.

From now on the only question is how fast and how far the Administration will move. Its definite plans will come out in the open with publication of the budget in January.

BLUE SHIELD FOR THE AGED

The Washington, D.C., area is contemplating a Blue Shield pilot operation that could point the way toward solving the critical problem of financing medical and surgical care for low-income families, including the aged population. Behind the move is Dr. Donald Stubbs, local Blue Shield president and chairman of the board of the national Blue Shield.

In a letter to the six medical societies in the Washington area, which work together on Blue Shield, Dr. Stubbs told the doctors bluntly that the new idea wouldn't work unless the doctors themselves are willing to handle low-income patients at less than their regular fees.

The plan has been under development for a number of months, and it will be still more months before it can be put into operation, even if the six societies decide to back it.

Briefly, the proposal is this:

The Washington area Blue Shield has a $6000 annual family income limit — families below this figure are cared for at the Blue Shield fee schedule; families above it may be charged additional by the doctors.

Under the proposed plan, there would be a low-income cut-off point, probably at about $3000. Families at or below this figure would be charged a lower rate than those above it, but they would receive the same service. There might be a readjustment of premiums for families whose income is above the cut-off. Blue Shield would not cancel policies when retirement age came, thus offering protection to a group presently posing one of the most difficult problems in medical economics.

Dr. Stubbs is not confident his ideas will be accepted, but he's hopeful. He is certain the medical profession has only a brief time to find a way to finance medical care for the indigent and the aged, or it will see Congress come through with its own solution.

RADIATION HAZARD

Is the American public overly excited about the danger of radiation from x-ray examinations? It certainly is, according to a number of prominent radiologists, and there is only one remedy: Substitute facts for emotion. (*Cont. on p.* 62)

This question was a conspicuous one at the Washington meeting (59th annual) of the American Roentgen Ray Society.

Said Dr. Robert R. Newell, San Francisco radiation researcher and physician and professor emeritus of radiology and biophysics at Stanford University School of Medicine:

"I would like to see less emotion in our fears and more logic. We ought to try to get our feet back on the ground. . .

"We have to live with radiation. Radiologists are the men who have the science and experience. This gives them the duty to explain radiation to everybody who will listen. Radiologists are the ones who use radiation on human beings. In this they have a duty to see that the harm to human health does not overtake the benefits to human health.

"The most effective and apparently the most difficult (recommendation) . . . to get adopted consists in limiting the exposure to the area of interest . . . . Obviously the gonads should be covered against the useful beam in every case if that area is not needed in the radiograph."

A National Academy of Sciences proposal that records be kept on every patient for every exposure was roundly condemned by Dr. Newell. "If the committee had included a practicing radiologist he could have made them understand how little such a record would mean."

Said Dr. George Tievsky, radiologist of Washington, D.C.: "Semi-hysteria has seriously clouded, in the public eye, the legitimate use of radiation for medical purposes . . . . **Patients are even hesitant about undergoing x-ray** examination of their teeth or chests, where exposure is minimal."

BACK-TO-STATES

Secretary Flemming is not without tenacity. This he demonstrated when he announced publicly that he would champion a cause that has almost no friends in Congress and powerful critics on the outside.

The head of the Department of Health, Education and Welfare is prepared to ask Congress to turn over certain specific health-welfare operations to the states, and at the same time open up new tax areas so the states can raise the needed money.

This back-to-the-states philosophy for several years has been popular with many students of government, one of the foremost of whom is Mr. Flemming himself. The theory is that unless concrete action is taken to reverse the present trend, the federal government, taxing as it goes along, will move so far in the health-welfare fields that there will be nothing left for the states to do, and no way to raise the money even if they could to recapture the programs.

Last session, while Secretary Folsom was in office, the Administration, supported by federal-state joint action committee (formed to look into this proposition), recommended that the U.S. drop its $50 million-a-year program of grants for water treatment plants and its $35 million-a-year program of grants for vocational education.

The states would then carry out these two programs at the present level or higher. To make financing possible, the U.S. would drop part of the tax it now imposes on telephone service, and the states would impose a telephone tax.

Congress showed no interest whatever in the suggestion, and eventually Secretary Folsom dropped it, explaining that the low-income states, where need is greatest for sewage plants and vocational education, couldn't raise enough on the telephone tax to keep up these projects.

The new Secretary isn't giving up so easily. He now has a plan to supplement the telephone tax revenue to the states with federal grants that would be so scaled that relatively more money would go to low-income states. His calculations, Mr. Flemming says, indicate that every state would have more new money for these programs than they now receive for them from the federal government.

While hospital problems are remote from sewage treatment plants and vocational education, this new idea is of more than casual interest. Should it somehow be approved by Congress (unlikely) and prove practicable, it could be applied to any number of Public Health grants, with a shift of Hill-Burton to the states not entirely out of the question. A major problem would be locating taxation fields from which the U.S. could withdraw, letting the states take the revenue.

SOVIET SOCIAL SECURITY

U.S. Social Security Commissioner Charles Schottland, back from a one month's tour of Russia, thinks that in at least three welfare areas this country might learn something from the Soviet Union.

Russian researchers have prepared pamphlets on every important disabling disease. Mr. Schottland is impressed enough with them to have them translated for the perusal of his medical advisory committee on disability.

In Russian institutions, at least a third of the old people are doing a certain amount of work on a voluntary basis but on a regular schedule and for pay. The social security chief thinks nursing homes and other institutions in this country perhaps could be doing more in this direction.

Russia's nurseries and old people's homes are "excellently" staffed. The nurseries have one employe for about two and one-half children, and the old folks' homes are one employe for about every three inmates. Mr. Schottland doesn't think our institutions can claim such a record.

The commissioner's remarks were based on data furnished him by the Russians, as well as on his own observations.

NOTES:

The antibiotic resistant staphylococci, which are causing hospitals so much trouble, received heavy emphasis at a three-day Washington symposium on antibiotics. Four of the sessions, including two panels, were devoted almost exclusively to the subject.

Head of the Pan American Sanitary Bureau is a Chilean, Dr. Abraham Horwitz. He succeeds Dr. Fred L. Soper, who has held the post for almost 12 years.

Complaints on Medicare restrictions continue to mount at the Pentagon, but they have not taken enough of a pattern to suggest what modifications if any should be made.

Doctors contemplating forming a clinic association to permit establishment of retirement plans have some encouragement from Internal Revenue Service. I.R.S. will handle each case separately, has no plans for a general ruling against — or in favor of — this device.

Public Health Service has available a booklet reviewing the first 10 years of the Hill-Burton program (1946-56). In addition to stacks of statistics and charts, it has such homey bits as the fact Benjamin Franklin devised a system resembling Hill-Burton for financing hospitals.

After first threatening to ban air mail shipment of etiological disease agents, the Post Office Department backed down completely; there'll be no change.

The Modern Hospital
NOVEMBER 1958

LOOKING AROUND

Down, Wisconsin!

SICKNESS insurance is sold the public on the basis that it will perform a social service. Its required operation as an insurance institution defeats this purpose. The fixation of premiums produces a situation in which the financial balance can only be maintained by ignoring the steady progress of medical science. . . . The institution, as a trustee, feels that its obligation to preserve the funds for the possible future needs of the many now in good health is paramount to its duty to give the best possible care to the sick. This of necessity involves exercising of a wide measure of control of medical practice."

So wrote the late J. G. Crownhart in 1938. As secretary of the State Medical Society of Wisconsin he had made a trip to Europe to observe the operation of government health insurance plans in England and on the continent, and his report* included this and other warnings that insurance would bring interference with the practice of medicine.

Interference with the practice of medicine is still the basic issue in a controversy between the State Medical Society of Wisconsin and Blue Cross, which was described last month by Dr. Dexter Witte of Milwaukee as a "monster." Early this year, the state medical society broke off a ten-year agreement under which Blue Cross was selling the state society's Blue Shield plan outside the Milwaukee area; the action was recommended by Charles H. Crownhart, brother of J. G. Crownhart and his successor as state society secretary. Since that time, Blue Cross has been selling a separate, Milwaukee County Blue Shield plan in competition with the state society's plan.

"Doctors started Blue Shield to meet the threat of socialized medicine, but today there is a greater threat of Blue Cross and hospitals taking over the practice of medicine," said Dr. Witte. "If the choice came between the government or hospitals taking over the practice of medicine, I'd take the government."

At a recent special meeting, the house of delegates of the state society voted to expel the Milwaukee County society if it continued to sell its own Blue Shield plan throughout the state, in competition with the state society. When doctors disagree, somebody usually calls the law, and it seems likely now this may happen in Wisconsin, as it has in other states. "The patience of the public is being sorely tried," the *Milwaukee Journal* observed recently. "If the end result should be some drastic legislation to assure that public protection, not professional preference, shall be the first consideration in Blue Shield and Blue Cross plans, the doctors should have no reason for surprise or complaint."

Ironically, it was just such regulation by legislation, and not insurance itself, that J. G. Crownhart feared most. "The care actually rendered the insured person when he is sick is not only limited directly by the regulations and rules but also indirectly by the subconscious desire of the physician to avoid doing that which will bring him into possible conflict with his administrative superiors," he wrote in his 1938 report. It may be that Wisconsin doctors have failed for twenty years to distinguish between the kind of government insurance Crownhart was worried about and our own voluntary Blue Cross plans. Thus far, nobody has produced substantive evidence showing that Blue Cross actually is seeking to dominate or control the practice of medicine, and it is positively hilarious to suggest that physicians in Wisconsin, or anywhere else, would be greatly influenced by a subconscious desire to avoid conflict with Blue Cross and hospital administrators.

*Sickness Insurance in Europe, by J. G. Crownhart, secretary, State Medical Society of Wisconsin, Madison, Wis., 1938

Warning

CHERISHED as it is by those who love it best, including its trustees, administrators and doctors, the voluntary nonprofit hospital doesn't mean much of anything to the public. In an extensive survey of public attitudes toward hospitals and hospital financing (see page 65) investigators found that most people haven't got the slightest idea of what a voluntary nonprofit hospital is and how it is different from a public hospital or a proprietary hospital. People form their opinions about hospitals, the survey indicated, on the basis of their experience in hospitals, and not on the basis of hearsay or publicity or newspaper or magazine articles. What happens in hospitals determines the public attitude toward hospitals, and, judging from the survey results, what happens in one hospital is pretty much like what happens in another, as far as public opinion is concerned.

On the whole, what happens isn't bad. Most of the respondents said hospitals do a fair job, or a good job, on most of the points considered. Inasmuch as what happens to people in hospitals is, by its very nature, essentially outrageous, this isn't a bad record; we can't reasonably expect that anybody is going to throw his hat in the air and cheer about an experience that is characterized chiefly by pain and fear. The fact that more than 50 per cent of people asked couldn't think

of anything unpleasant to say about hospitals seems remarkable under the circumstances.

Certainly there are indications in the survey that hospitals might do better than they have been doing in personalized attention and friendly interest in patients and visitors. These are important goals, and they need to be sought for systematically with hospital personnel in all classifications.

Public attitudes about financing hospital care are considerably less reassuring than the public attitude about hospital care itself, the survey revealed. Most of the people interviewed were paying for their hospital and medical care through some form of prepayment, and they had only the vaguest idea of what they were getting and how much it cost. Yet half of them didn't hesitate to say that hospital costs are too high — an opinion which has resulted in political action affecting hospitals, in New York and elsewhere. Moreover, the survey indicated that many people are confused about the difference between Blue Cross and Blue Shield; a substantial number thought Blue Cross paid doctors' bills and Blue Shield paid hospital bills. In the hospital field and the medical profession, the medical care and management functions are sharply differentiated, but, obviously, no such distinction is made by the public. There may be a lesson here in connection with planning prepayment programs, and possibly also in connection with the way medical and hospital services are organized and paid for generally.

The most alarming thing of all about the survey results is the apparent willingness of all groups to consider that hospital financing should be the responsibility of the federal government, or should be included in Social Security, or become a function of state or city governments. Apparently, those who believe it would be better to keep the larger part of our medical and hospital care system, as it has been in the past, in the hands of private, voluntary enterprise have failed to convince the majority of their fellow citizens of the advantages of their jurisdiction.

This is not just a failure of hospital public relations. If we are to persuade people of the desirability of free, voluntary, nonprofit hospitals, as opposed to subsidized hospitals, we shall have to do it not by the use of slick public relations technics but by the provision of better and better hospital care and better methods of paying for it, because opinions about hospitals are formed on the basis of experience, not by publicity. If the advantages of voluntary free enterprise in medicine and hospitals cannot be demonstrated to the public on the basis of the public's experience, then they cannot be demonstrated by any other method.

No Laughing Matter

SPEAKING at a recent medical society conference, an obstetrician described husbands as a nuisance. "A husband merely adds to the problems of the nursing staff," he added. "Husbands must be screened, watched, labeled and guided. We always pray there will be no husband present. Husbands are pests and really want nursing themselves."

Catching the uproarious idea, another obstetrician told about a husband who passed out cold in the hospital corridor and had to be treated for a fractured jaw. The anecdote evoked broad grins and general nodding of heads in approval.

Certainly if the presence of the husband in the labor or delivery room adds to the hazard of infection, he should be excluded or supervised so that the infection hazard is eliminated. Moreover, the husband who gets in the way or requires looking after himself, diverting attention from the care of the mother and baby, may properly be considered expendable.

However real these practical problems may be, obstetricians who refer to the husband as a nuisance or a pest, even among themselves, reveal a sad lack of understanding. The most damaging thing that can be said about medical care in the hospital today is that for all its mechanical perfection it sometimes overlooks the human, psychic needs of patients. Many psychiatrists and family physicians believe that seeds of family disunion may be sown when the husband is excluded from the labor and delivery rooms, barred from seeing his new baby except behind glass and at a distance, and generally made to feel unneeded and unwanted throughout his wife's confinement.

Of course, it is easy to label these concerns as rubbish and keep on excluding husbands because of the infection problem or because they are nuisances. But thoughtful physicians and hospital administrators might ponder the fact that in some cities a few women are having their second or third babies at home, preferring the risk of infection or complication to the impersonality of hospital routines and the indifference or hostility of hospital personnel. Obstetricians who laugh about fathers discredit their profession.

Strike

THE protracted and costly strike at Swedish Hospital, Seattle, earlier this year proved again what labor leaders should have learned long ago: You can't strike a hospital and win.

In this case, 85 housekeeping and dietary employes walked off the job and stayed out for three months, during which the hospital was picketed and some damage to hospital property occurred. Eventually, the dispute was "settled" with a few concessions that permitted face-saving claims to be made, if not believed, but essentially the strike was called to force recognition of a union as the bargaining agent for this group of employes, and no such recognition was granted.

From the beginning, public sentiment in Seattle, a strong labor town, was solidly against the union — as public opinion invariably is in a hospital strike. Whatever the merits of the dispute, there is something so essentially indecent about making the sick and injured suffer for the monetary grievances of a group of workers that the public always reacts against a hospital strike. If necessary, doctors will run elevators and laundry machines, trustees will carry patients and push wheel chairs, and volunteers will spring up out of the ground to perform any needed service. The strikers have no chance of developing the kind of pressure on management that results when work stops in industry; instead, the pressure backfires, leaving the strikers in the position of a man who has been caught beating his aged mother.

We are in favor of good wages and good working conditions for hospital employes of all kinds, even when a raise in wages means an addition to hospital bills, and we are opposed to hospital trustees and administrators who use their responsibility to the sick and injured as a screen behind which to hide inadequate wages and shabby personnel practices.

But a union that strikes a hospital strikes a blow at the sick and injured, who are innocent of wrongdoing. A hospital strike is a disservice to the public and, most of all, a disservice to unions and union members everywhere, who thus become associated in the public mind with an indecent act.

A public opinion poll conducted recently in New York shows that

The public likes doctors better than hospitals

NEW YORK. — Hospitals do a fair to good job, performing most effectively in the area of scientific skills and leaving most to be desired in the friendly, personal care patients feel they should have.

That is the summary verdict of a public opinion survey of hospitals reported here last month. The survey was conducted by Elmo Roper and Associates for the United Hospital Fund of New York to determine public attitudes toward hospitals and hospital financing in New York City and the suburban area.

Other findings of the survey were:

1. Few people understand the voluntary, nonprofit concept.

2. Most people favor the solution of hospital financing problems through federal, state or city governments rather than private contributions.

3. The majority of those having hospitalization insurance don't know what it covers or how much it costs.

4. Whatever their opinions about hospitals, most people form them on the basis of personal experience as patients or visitors, not from what they read or hear.

5. Among people who contribute to charitable causes, specific disease philanthropies are greatly favored over hospitals as a means of helping science combat disease.

The survey was conducted by

Table 1. Evaluation of Hospitals by the Public

	Summary Score*
Doctors	200
Way visitors are handled	166
Student doctors and interns	164
Nursing care during the day	163
General appearance and condition of the buildings	152
General attitude of the hospital staff toward the patients	152
Way they attend to the patient's personal needs	138
Way they treat patients when checking them in	136
Food	133
Other hospital employes	129
Nursing care during the night	126
Volunteer workers	123
Way they handle arrangements for paying the bills	113

*200 = "Good"; 100 = "Fair."

Table 2. How They Think Hospitals Should Get Money

	Urban Sample	Analyzed by Respondents Who Are:		Analyzed by Respondents Whose Economic Level Is:		
		Male	Female	A or B	C	D
	1150=	569=	581=	137=	656=	328=
	100%	100%	100%	100%	100%	100%
The federal government should give the voluntary hospitals more tax money	40 %	44 %	36 %	42 %	41 %	38 %
Social security should include hospital insurance	39	39	40	42	41	37
The state should give the voluntary hospitals more tax money	37	40	33	44	36	37
The city should give the voluntary hospitals more tax money	29	30	28	34	27	31
The hospital patients who can afford it best should be charged more	20	19	20	20	19	23
The public should contribute more money to the voluntary hospitals	17	20	15	25	15	19
The hospital patients who don't have much money should pay their full share, but do it in installments	15	13	18	21	13	19
People should be charged more for their hospital insurance	4	6	2	7	3	5
If the voluntary hospitals were more businesslike, they wouldn't need any more money	4	5	4	7	4	3
The voluntary hospitals are fine as they are and they don't need more money	1	*	2	—	1	1
Other comments	2	3	1	1	2	1
None	*	1	—	1	*	—
Don't know or no answer	7	5	9	6	7	9

*Less than 0.5 per cent.
Note: Group totals add to more than 100%, and subtotals may add to more than group totals because some respondents gave more than one answer.

THE PRESENT STATUS OF

means of interviews with 1150 New York City and 355 suburban residents. The findings were classified according to the sex, age, education, economic level, and hospitalization experience of the respondents, but a major result of the survey was that the attitudes revealed only minor variations among these groups on most points. "Opinions about hospitals, hospital insurance, and hospital financing show only minor differences between men and women, old and young, prosperous and poor," the report said. "Opinions tend to be across the board."

Asked to make a general evaluation of hospitals at the beginning of the interviews, 55 per cent of all the respondents said hospitals do a good job, considering the money they have to work with. Twenty-two per cent said hospitals do a fair job, and 9 per cent said they do a poor job.

In contrast, only 34 per cent of the group said schools do a good job, but 77 per cent said the fire department does a good job.

The best thing about hospitals is their doctors, and the worst thing is the way they handle arrangements for paying bills, the respondents said in a detailed evaluation of performance in 13 separate areas covered during the interviews. In each of the 13 categories, respondents were asked to rate hospitals as very good, fair or poor. Then summary scores were worked out for each of the points, so that a score of 100 was equivalent to fair and a score of 200 equivalent to good. The results (see Table 1) indicated that only the doctors were considered good; on most points, hospitals were rated a little better than fair.

"The range between the lowest and the highest scores is only from a little better than fair up to good," the report noted. "There are no summary scores even approaching very good or poor, so differences should not be overemphasized, but the difference between the highest six points and the others is worthy of note. The lower seven points offer challenging opportunities for improvement. It is interesting to see that all seven relate rather personally to the patient's feelings, aside from the

OPINION IS GENERALLY FAVORABLE BUT LEAVES ROOM FOR IMPROVEMENT

purely professional relationships incident to hospitalization."

After they had given their ratings, respondents were asked to state whether their feeling about hospitals derived from experience as a patient, or impressions received as a visitor, or from working in hospitals, or from another source.

Forty-six per cent replied that they had been thinking mostly as patients, and 32 per cent said they were thinking mostly as visitors. Twenty per cent said they had been thinking in terms of general impressions or didn't know what their point of view was.

"With few exceptions, people's opinions about hospitals stem from face to face experiences in hospitals," the report said. "Hospital personnel, accordingly, have a challenging opportunity to influence public opinion without going beyond the walls of the hospital.

"The present status of opinion, while generally favorable, leaves substantial room for improvement. The primary source of opinions about hospitals lies in personal interaction within the walls of the hospital. The focus of negative opinion about hospitals lies in the areas of personal interaction within hospitals."

Most people don't make any distinction among voluntary, public and proprietary hospitals, it was indicated. "The state of information about voluntary nonprofit hospitals as different from proprietary and public hospitals can be judged by the fact that only in the 48th of a 50-question interview were these terms introduced," the report said. "Preliminary interviews had indicated that when the terms were introduced, they would have to be carefully defined. Respondents had no difficulty nor did they raise objections to going through almost the whole interview simply talking about hospitals.

"When asked whether some hospitals are much better than others, or whether one is pretty much like the others, 20 per cent said one is pretty much like the others. When those who said some are much better than others (67 per cent) were asked to describe some of the differences, 7 per cent contrasted city and private hospitals, and 4 per cent referred to differences in administration. The words 'voluntary' or 'nonprofit' or other words conveying similar meaning practically never were used."

An especially interesting result of the survey was that the whole group proved just about evenly divided among those who think hospitals make money, those who think hospitals break even financially, those who think hospitals lose money, and those who admitted they didn't know.

"It is unusual for a 'plus, neutral, minus, don't know' question to have so nearly 25 per cent of the responses in each alternative," said the report. "These responses are of basic importance because they epitomize the confusion, the absence of any clear image of the financial status of hospitals. The A and B economic group (prosperous) shows somewhat more insight, but even among this group, 39 per cent believe that hospitals in general make money or break even on income derived from insurance and patient fees."

Preceding a final question about financial support of hospitals, the respondents were given a definition of public, proprietary and nonprofit hospitals. Then they were told that authorities in the nonprofit hospitals say that income from patients, tax money, and contributions doesn't add up to enough to keep the hospitals as good and up-to-date as they ought to be. "Here are a number of statements," the interviewers said. "Do any of them come close to the way you feel about financial support for voluntary nonprofit hospitals?"

The answers (see Table 2) showed a clear pattern of dependence on government financing. "By this point in the interviews, respondents had been discussing hospitals and related problems for some 30 to 45 minutes," the report said. "Problems, preferences and experiences had been explored, and respondents can be presumed to have answered this question in a context of more thought about hospitals and their finances than they would normally devote to these subjects.

"The proposition that the public should contribute more money to the voluntary hospitals was not frequently chosen. The relative absence of a sense of individual responsibility and affiliation is apparent. The atmosphere of moderate approval regarding hospitals is confirmed here in a pattern of response that seems to say, 'They should have more money, but let the government take care of it.'"

Seventy-one per cent of the city and 83 per cent of the suburban residents had some form of hospitalization insurance, but nearly all were confused about the kind and amount of insurance they had, and what they paid for it. For example, when asked if they had insurance that covered doctors' bills, 25 per cent of the city and 32 per cent of the suburban residents said, "Yes, Blue Cross." Moreover, about 6 per cent of the respondents thought that Blue Shield covered their hospital bills. Most of the respondents thought their hospitalization insurance was rea-

Table 3. Evaluation of Hospital and Insurance Costs

	Hospital Insurance	*Hospital Bills*	*Doctors' Bills*
	%	%	%
Too high	11	53	44
Reasonable	58	30	43
Really quite low	5	1	2
Don't know or no answer	26	16	11

Table 4. What They Liked About Hospitals

People often say that they remember both pleasant and unpleasant things about hospitals. Let's start with the pleasant memories. As you think back about your experiences, or what you have heard about hospitals, does anything pleasant or especially good come to mind?

	Urban Sample	Analyzed by Respondents Who Had: Recent Exposure to Hospitals	No Recent Exposure to Hospitals
	1150=	540=	610=
	100%	100%	100%
	%	%	%
Personnel was pleasant, nice, attentive	40	46	34
The personnel was pleasant, friendly, attentive, gave good care	19	21	17
Nurses were nice, cheerful, good	16	19	13
Doctors were pleasant, nice, tops	8	7	8
Attendants were considerate, pleasant	1	1	1
Volunteer workers were nice	1	1	1
Nurse's aides were nice to me	*	1	*
Intern was considerate	*	1	*
Other (personnel was pleasant, nice, attentive)	1	1	2
Administration	10	11	9
Good food	4	4	3
Clean rooms, hospitals	3	2	3
Cheerful rooms, hospital	2	3	1
TV, radio in rooms	1	1	1
Clean sheets, gowns	1	1	1
Other (administration)	2	2	1
Hospitals save lives, make people well	4	4	4
Fellow patients cheerful, congenial	2	2	2
The rest you get, getting a good rest	1	1	1
All other	5	5	5
Nothing	7	6	8
Don't know or no answer	40	35	43

*Less than 0.5 per cent.
Note: Group totals add to more than 100%, and subtotals may add to more than group totals because some respondents gave more than one answer.

sonably priced; only 11 per cent thought it was too high, as against 53 per cent who thought hospital bills were too high (see Table 3). However, when asked what their insurance covered, less than half knew how many days of hospital care was included as a Blue Cross benefit, and only 1 per cent knew they were entitled to an additional period of half coverage.

"There is widespread confusion between Blue Cross and Blue Shield," the report said. "It is probable that some people think they have Blue Shield but don't, since practically equal numbers called insurance for doctors' and surgeons' bills Blue Cross and Blue Shield."

Most of the Blue Cross members thought they were paying more for Blue Cross than they actually were paying, it turned out; only 13 per cent of those with Blue Cross made an accurate estimate of the subscription cost.

Reminded that hospitalization insurance doesn't cover the entire hospital bill, 55 per cent of the city and 65 per cent of the suburban residents said this was because insurance isn't supposed to cover the entire bill, but 10 per cent of the city and 11 per cent of the suburban residents thought that hospitals increased charges to patients with insurance, and an equal number thought this was part of the reason they had to pay.

One of the questions in the survey asked respondents to imagine they had $1,000,000 to give to hospitals and then offered a number of choices as to how the funds would be allocated.

The replies given should be of interest to hospitals with fund-raising projects. The outstanding appeal among the 10 alternatives was to help provide up-to-the-minute, scientific equipment in hospital laboratories and operating rooms. "This unusually strong response suggests that some of the dramatic appeal so many people find in the disease philanthropies (*i.e.* American Cancer Society, American Heart Association) can also be associated with hospitals," the report said. "Up-to-the-minute, scientific equipment for hospital laboratories and operating rooms raises an image of specific, tangible combat with a killer or a new and dramatic saving of lives, or of new cures or surgical technics. Such a project seems to catch the imagination."

The second most popular project was: "Help to make the hospitals big-

ger so more patients can be accommodated." Sixteen per cent gave this project the biggest gift, and 60 per cent gave it $50,000 or more.

"By way of contrast, consider the response to deficit financing," the report pointed out. "This appeal was presented as follows: 'Help meet the financial losses that any of the hospitals might have at the end of the year.' Only 5 per cent gave this project the $500,000 gift, and only 23 per cent gave it any gift.

"Another project with relatively little appeal was: 'Give a gift, without any strings attached, to one particular hospital that you are especially interested in.' Only 4 per cent gave this project the $500,000 gift, and only 20 per cent gave it any gift. The response on this project is of interest because it suggests the absence of strong appeal in the hospital as a local, or neighborhood, institution. This finding was confirmed in other sections of the study. For example, when respondents were asked what hospital they would probably go to if they got sick, and were later asked to name the closest hospital, their answers indicated that only 13 per cent could both name the closest hospital and would probably go to it if they got sick.

"The local hospital appears to have rather limited appeal. There seems, at this point and time, to be a greater appeal in concepts with broader scopes, particularly those that carry connotations of high level, all out, scientific attacks on specific targets."

Earlier, it was reported, 69 per cent of the respondents who were identified as givers to philanthropic causes had indicated that cancer, heart disease and cerebral palsy funds were more important and deserving of more support than other charities. Seventeen per cent named the American Red Cross, 12 per cent the community fund, 9 per cent the United Hospital Fund, and only 3 per cent the local hospital.

To summarize their feelings about hospitals, respondents were asked to recall things that were "pleasant or especially good," on the one hand, and "unpleasant or especially bad," on the other, about hospitals – either from their own experiences as patients or visitors, or on the basis of hearsay. The results (see Tables 4 and 5) confirmed the earlier finding or evaluation of hospitals as fair or moderately good. Sixty per cent recalled something positive, but 40 per cent could not think of any-

Table 5. What They Didn't Like About Hospitals

Now does anything that was unpleasant or especially bad come to mind about hospitals or the way things were handled there?

	Analyzed by Respondents Who Had:		
	Urban Sample	*Recent Exposure to Hospitals*	*No Recent Exposure to Hospitals*
	1150 = 100%	540 = 100%	610 = 100%
	%	%	%
Personnel was rude, inattentive, unpleasant	18	21	15
Poor service, lack of attention; long wait for help, attention	8	10	7
Personnel was rude, unpleasant, inconsiderate	8	9	7
Took advantage of charity cases	1	1	1
Unfriendly atmosphere	*	*	1
Other (personnel was rude, inattentive, unpleasant)	1	1	1
Administration	15	16	14
Understaffed; not enough nurses, help	3	4	3
Poor food	3	3	3
The dirt and filth	2	2	2
Very sick people should be put in separate rooms	1	1	1
Overcrowding	1	1	1
Admitting procedure bad—lack of help, attention	1	1	1
Noise	1	1	1
Unreasonable time schedule; strict adherence to schedule	1	*	1
Personnel not fully trained, not up to par	1	1	*
The smell	*	*	1
Ambulance service slow	*	*	*
Other (administration)	3	3	2
Just having to be there; the sickness and suffering	5	6	5
Bad medical care, treatment (wrong or poor diagnosis, fatal treatment, etc.)	4	5	3
Money	3	5	1
High cost of hospital care	1	2	1
Won't admit you unless you can pay; ask for money even in an emergency	1	1	*
Other (money)	1	2	*
All other	3	3	3
Don't know or no answer	58	52	63

*Less than 0.5 per cent.
Note: Group totals add to more than 100%, and subtotals may add to more than group totals because some respondents gave more than one answer.

thing good to say. In contrast, 58 per cent of the respondents were unable to recall "unpleasant or especially bad" experiences, although 18 per cent found fault with hospital personnel, 15 per cent criticized various aspects of hospital administration, and 4 per cent reported criticisms relating to professional medical factors.

"Respondents were then asked an 'incomplete sentence question' designed to cut through social inhibitions and expose partly conscious feelings," the report said. "In response to this question, many more people expressed negative feelings, and the resentment of inconsiderateness and rudeness bulked much larger (44 per cent) in comparison with criticisms of administrative factors (11 per cent).

"Among those who had no criticisms when asked the straightforward question, more than half broke through their reserve and expressed the same kinds of personal resentments that less inhibited respondents expressed: 'Members of the hospital staff could at least be more considerate, more tolerant, more sympathetic, give more personal attention, answer the bell, get more help, do their duty, etc.'

"It is understandable that people are reluctant to express criticisms that might be characterized as 'hurt feelings' about an up-to-the-minute scientific institution that, after all, devotes itself to saving lives and restoring health. But this reservoir of feeling, which might be summarized as resentment of neglect during a time of helplessness, plays its role whether expressed or not when a person decides to give or not to give to hospitals.

"So feelings toward hospitals in general range from a high degree of approval on the scientific, medical side to a partly submerged feeling of disapproval on the personal side." ■

Table 6. How They Would Improve Hospitals

Now I want to start a sentence about hospitals and I'd like you to finish it with whatever pops into your mind. Here is the start of the sentence and when I stop talking, you just finish it with whatever pops into your mind. "I know they are busy and have lots of people to take care of, but it seems to me that they could at least _____."

	Urban Sample	*Analyzed by Respondents Who Had: Recent Exposure to Hospitals*	*No Recent Exposure to Hospitals*	*Analyzed by Respondents Who, in Table 5, Said "Don't Know"*
	1150 = 100%	540 = 100%	610 = 100%	641 = 100%
	%	%	%	%
Personnel should minister to patients' needs	44	48	41	34
Be more considerate; be tolerant, sympathetic, kind, cheerful, pleasant	22	24	20	15
Give patients more attention; more personal and individual attention	13	13	12	10
Answer the bell when you ring; give quicker service	4	4	4	3
Take care of the patients	4	4	4	3
Give special care to the seriously ill; take care of those that need it, first	2	3	2	2
Other (minister to patients' needs)	1	1	1	1
Administration	11	13	10	8
Have more, enough, help	6	7	6	6
Admit people more quickly and courteously	1	1	1	1
Keep the hospital clean	1	1	1	*
Have better food	1	1	*	*
Pay the help more	*	*	1	1
Have better qualified, more experienced help	*	1	—	—
Other (administration)	2	2	2	1
Do better work; apply themselves more; do their duty	6	7	6	7
No complaints against hospitals; they do the best they can; do a good job	4	3	4	5
Treat visitors more courteously	1	1	1	1
Charge less money	1	*	1	1
All other	2	3	1	2
Don't know, nothing or no answer	32	28	36	43

*Less than 0.5 per cent.
Note: Group totals add to more than 100%, and subtotals may add to more than group totals because some respondents gave more than one answer.

Circular Nursing Division Runs Rings Around Rectangle

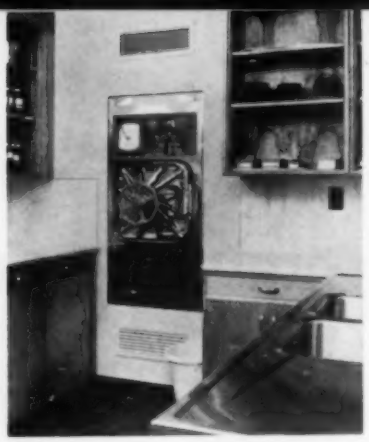
Above, left: The new Special Observation Unit is attached to the second floor of the main hospital building. Above, right: Centrally located nurses' station. The charting area is equipped with lazy susan device.

Plan of intensive care unit at Rochester Methodist Hospital. The pie-shaped bedrooms, each with subutility section, are arranged around the three-part nurses' station. Building is 67 feet in diameter.

THE shape of things to come in hospital design may very well turn out to be a circle. The circular shaddow is being cast by an experimental, 12 bed intensive nursing unit opened last December by Rochester Methodist Hospital, Rochester, Minn., of which Harold C. Mickey is the administrator.

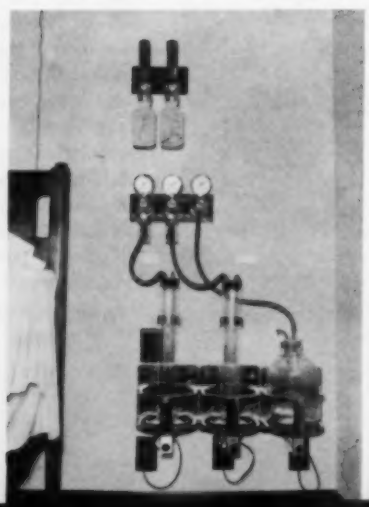
Designed by Ellerbe and Company, hospital architects of St. Paul, the Special Observation Unit, as it is officially designated, is the outgrowth of three years of study and planning by the administrative and nursing staffs of Rochester Methodist, with the enthusiastic collaboration of the Mayo Clinic, whose physicians and surgeons staff the hospital.

Intensive care patients were selected for the initial experiment because studies in Rochester revealed that care of these patients accounted for 21 per cent of the total "hospital days" and also because their needs have not been studied as intensively as have those of moderately ill and convalescent patients. Furthermore, hospital officials point out, although advances in medicine have shortened the average length of stay in a hospital, they have also contributed to a great increase in the number of employes required to care for patients because



Top, right: Sterilizer in the large utility room. Below: Third section of the nurses' station, showing how undercounter stools are tucked away.

Right: Medication area in nurses' station contains medication cubicle for each room, warning lights to indicate when the various suction bottles are full.



Right: Every room has three levels of suction on separate outlets, for the greater safety of the patients.

ABILITY TO SEE NURSES

the new procedures are so complex and time consuming. The net result has been a steady rise in costs, chiefly because of the increase in the ratio of personnel to patients.

The board embarked upon the research project in an effort to discover whether changes in the layout and construction of nursing units and other services would provide more efficient and less expensive ways of caring for patients. Those dealing with this patient-centered activity were charged with keeping ever present in their minds that nothing should dictate the size, shape, layout or function of this nursing care area except the needs of the patient.

The Special Observation Unit is housed in a circular two-story building (see cut) attached to the main hospital by a bridge. The nursing unit is on the second floor and the ground floor contains the necessary mechanical equipment and utilities. This temporary structure will be torn down when the studies have been completed.

Half the cost of it was paid by a grant from the Louis W. and Maud Hill Family Foundation of St. Paul and the other half by a portion of a Ford Foundation grant. An additional $50,000 grant for research was presented by the W. K. Kellogg Foundation.

Control Unit Set Up

To establish a check on the studies carried out in the circular unit, a control unit has been set up in the hospital proper. This control unit is provided with approximately the same type of equipment, supplies and personnel as the research area and serves the same type of acutely ill patients.

The only difference is that it is a conventional rectangle with rooms off on both sides of the corridor. This was done to enable research workers to

GIVES PATIENTS FEELING OF SECURITY AND REDUCES NUMBER OF CALLS

compare the results in the two units and determine which affords the greater economy in space and equipment and the more efficient utilization of nursing time.

The round nursing unit consists of 12 private rooms that are placed around the edge of the circle, with the nurses' station in the center and a large utility room at one side (see plan). The nurses' station is enclosed by a low counter and divided into three sections.

It has been equipped with a control panel of lights and signals that keep the nurses in constant touch with their patients. For example, warning lights at the nurses' station indicate when a suction bottle in a patient's room is full and must be replaced. Later, it is hoped one section of the station will hold monitoring equipment for electronic devices that will record each patient's blood pressure, pulse, temperature and respiration.

Nurses Have Direct Vision

The central location and low counter of the station, as well as the glass doors that form the inner wall of the patients' rooms, permit the nurses to keep patients under direct visual observation. And the distance (15 feet) between station and beds ensures that no time is lost getting to patients when the need arises.

All patient rooms are basically of the same design although they vary in some details of furnishing and equipment for purposes of experimentation. The inside wall of each room, as has been mentioned, is formed by two glass doors. Normally, just the section closest to the patient's head is used as a door, but both sections can be opened to permit the transfer of a patient in his bed.

Windows May Be Omitted

Each room is equipped with the customary piped oxygen and compressed air outlets; in addition, each has three levels of suction on separate outlets for greater safety. Temperature and humidity are regulated by individual controls, and odors and stale air are vented to the outside while fresh air is drawn into the rooms. A subutility room accommodating the toilet, wash basin, work counter, and storage space for frequently used equipment and supplies is incorporated in each patient's room. Walls, floor and ceiling are acoustically treated.

Studies are being made on such details of construction as the proper location of subutility rooms in relation to the patients' beds. The idea was advanced that an acutely ill patient doesn't know or care whether his room has a window or not; therefore researchers are experimenting with an illuminated scene in place of a window in one of the rooms. If the lack of windows doesn't prove disturbing, hospital officials point out, it may be possible to utilize inside areas, provided they are air conditioned, for patient rooms, a departure heretofore considered unthinkable.

Left: This is a view of a corner of the subutility area in a typical patient's room.

Many kinds and sizes of such standard items of equipment as beds, lights, doors and latches, bedside stands, closets and cupboards are being tested to find the ones that appear to be best suited to the needs of an intensive care unit. One example is the "headless" bed. Someone suggested that a head serves no useful purpose for an acutely ill patient and is actually in the way of doctors and nurses when they are treating the patient's head or neck. Whether this argument is valid will be decided after evaluation of the bed.

Below: Stationary bedside table is being tested in this room instead of a conventional, movable stand. The furnishings in the rooms have been varied for experimental purposes.

Hospital officials and the architects emphasize that the special unit is a research project and that adaptation of the ideas and facilities currently being studied to a projected new hospital will have to wait until they have been thoroughly tested, evaluated and, where necessary, modified.

The round plan has much to offer and certainly merits all the study and effort being put into it. ■

Complaints Show the Way to Better Care

Patients' complaints about hospital care should be regarded as evidence of administrative failure, the author says. Every complaint should be studied by the administration to find out what happened, why it happened, and how it could have been prevented

Richard T. Viguers

A PRODUCTIVE administrative attitude is that every patient complaint indicates an administrative failure. This does not mean that with our present knowledge of administration and the human and physical resources available we could have prevented the complaint or the situation that gave rise to it, but it does mean that we should examine every complaint critically to see if the dissatisfaction of the patient could have been prevented. In the perfect hospital run by perfect individuals there would be no complaints. While this situation does not and never will exist, it does furnish a goal toward which we should strive. Critical analysis of patient complaints puts the emphasis where it should be — on the administration of the hospital — and not where it is too often wrongly placed — on the patient.

Make a "Clinical" Study

A patient complaint about hospital care should be reviewed in somewhat the same way that the medical staff of the hospital reviews the death of a patient. Death is regarded as a clinical failure. Clinical review of the entire case is made not only by the physicians directly involved, but the entire staff or service. The entire patient's course is reviewed along with what was done, the necropsy report, and what might have been done.

Of course, in most cases, while this is an important teaching experience, the final conclusion will be that in the present state of knowledge of medicine there was nothing that could be done to have prevented this clinical failure. In other cases there will be indications of other methods of treatment which might have changed the patient's course and there is also the education of the members of the staff by the discussion of the various courses of action which might be followed.

The patient's complaint about hospital care should be reviewed in much the same manner. There should be a review of the background of the situation leading to the complaint, some "postmortem" report by a person not involved directly in the situation, a consideration of what was done, what could have been done, and what course of action might have prevented the dissatisfaction. Just as in the case of the clinical failure, even after a careful review, the decision usually will be that with the present state of knowledge and the resources available, the dissatisfaction could not have been prevented. On the other hand, there will be the constant stimulation toward developing methods which would have prevented the dissatisfaction or toward improving the ability of the personnel and increasing the physical facilities.

This is a time consuming procedure, and administrative staff members usually find themselves busy for more than the usual workday. However, the evaluation of complaints can be an important basis for improvement in hospital care and it can give us the stimulation and educational experience to improve patient care.

If patient complaints can have this basic value in the improvement of patient care, it is important for administrators to hear of the complaints that patients have. The dissatisfaction which a patient has with some aspect of his care, if not expressed at all or expressed only to family and friends outside of the hospital or even if expressed to employes but never passed on to the administration, does not serve directly as a useful basis for improving patient care.

The widely used method of evaluating the patient's feeling about the hospital and the care rendered is the questionnaire. Some hospitals use a standardized form and others develop their own. For the last 10 years we have used a questionnaire that covers nine general areas. This questionnaire is given to all patients at the time of discharge with a prepaid, return envelope. The questionnaire is structured to ask certain specific questions, but it leads up to an unstructured final question — "If you were the administrator of the hospital, what changes or improvements would you make?" — which brings forth many of the most useful comments. We have found that if we merely ask the patient to comment on his hospital stay, we get few useful replies, but if there is a check list leading up to the final general question, we get a high percentage of valuable comments.

The questions are aimed at the various departments: admitting, nursing,

Mr. Viguers is administrator of the New England Center Hospital, Boston.

dietary, housekeeping and accounting. Then there is also the question aimed at the patients' evaluation of the professional care they received. This reads – "Did you feel that you were treated as an individual ———, just another case ———, or a machine without personal feelings?" While the patient may not know whether he recovered because of or in spite of the professional care he received, he does know whether or not he felt that he was treated as an individual.

These questionnaires must, of course, be reviewed and, where indicated, a letter should be written to the patient. Often there is an opportunity to correct a misunderstanding or to explain a situation which would otherwise result in a strong antagonism against the hospital by the patient. Furthermore, there should be a monthly tabulation of the answers to see if any trends are observable. To use the questionnaire merely to give the patient a chance to let off steam is to miss the opportunity to acquire an important and useful administrative tool.

Make the Rounds

Another way to get complaints from patients is for the administrative personnel to make rounds and talk to patients at some length to get their reactions to the care they are receiving. While this is a good practice, and administrators tend to become too desk-bound, nevertheless it usually does not produce a great number of complaints unless the administrator is particularly skillful in this matter. It is much more likely for the patient merely to repeat the good things that he feels about the hospital and to hide his dissatisfactions.

Another interesting way to hear patient complaints and to evaluate them is administrative rounds. This has been used only in a limited way, but it has considerable potential usefulness. This plan calls for a weekly or monthly meeting of all administrative personnel department heads in the hospital, and several selected patients are brought to this meeting. Some of the clinical background is presented so that there can be a general understanding of the patient's problem. Then the patient is brought into the room and a discussion is held with him by the administrator or someone appointed by the administrator.

To be successful, this procedure requires carefully selected patients who are critical of the hospital, the establishment of rapport with them so that they are willing to voice their criticisms, and then a discussion by the department heads of the patients' comments. In nearly every case the patient really enjoys this opportunity to occupy the center of the stage and tell his side of the story. This meeting is obviously modeled on the medical "grand rounds" and has most of the same opportunities for a stimulating and useful educational experience. An important method for gathering

It Wasn't the Food—It Was the Service

All too often a complaint is handled something like this. One of the doctors comes to the administrator and says that his patient, Mrs. Jones, says that the food is terrible and that she cannot eat it, and that he agrees the food is terrible. The administrator immediately replies that the food in the hospital is good, that all the patients say that it is good. The administrator then goes to the dietitian and passes on the complaint about the food. The dietitian replies to the administrator saying that, in the first place, Mrs. Jones is an "impossible" patient and would not be pleased with any food, and, in the second place, the dietitian works terribly hard, she works with a very limited budget and it is difficult, if not impossible, to get competent personnel with the low salaries she is allowed to pay. The dietitian then turns and blasts the assistant who is in charge of the ward where Mrs. Jones is a patient. The assistant blames the nurses and doctors for failure to cooperate, so that the food is always cold by the time the patients get a chance to eat it and so on.

However, the fact that the patient did not like the food indicates an administrative failure even if it is the best food in the world. In a somewhat similar situation, where we were getting continued complaints from one area, we studied the situation in some detail. The food seemed well prepared and hot when served; the menu was varied but still there were complaints. Finally, as a result of a discussion, we decided that it might be the attitude of the dietary aides that was responsible. The dietitian then instituted a special program with the dietary aides impressing the fact that they should have a pleasant smile when they served the food, have a few words with the patient about how good the food was, that they should return to the patient's room to ask if he wanted anything else, if the patient wanted more coffee, and so on. This change in attitude by the dietary aides apparently improved the situation because the number of complaints from that area dropped off to virtually none and we began to get praise for the food.

One Change Usually Leads to Another

Often, in order to correct one situation a whole series of changes is necessary. Our admitting office called attention to the fact that many patients were kept waiting for several hours to be admitted because patients in the hospital were not leaving until late in the day and rooms were not ready for the incoming patients. This led to establishing a one o'clock checkout time for all patients or the charge of an additional half day. The result of this was a great number of discharges just about one o'clock, so that patients leaving the hospital had to wait a considerable time in order to pay their bills at the cashier's window. This led to a further revision so that the checkout times on the various services were staggered. It also called our attention to the fact that the cashier's window on a corridor is not a really adequate place for a patient to pay his bill and, although we have not been able to change the facilities, we are considering a room where patients may sit comfortably while waiting to pay their bills and where the cashier can sit down and explain the bill to the patient.

Little Things Mean a Lot to Patients

We have elicited a good many useful comments from the questionnaire. Many are about small things but they can be extremely important to a patient. For example, a patient called our attention to the fact that the water cooler outside of the room was very noisy. Another patient pointed out that the maid in one of the units was going around collecting the dirty towels and then coming back about two hours later and putting clean towels in the rooms, which meant there were no towels for a period of two hours.

Another patient on the ambulatory service pointed out that when he came in to have some diagnostic tests done he had to get undressed for a chest film in the x-ray department, then get dressed and walk down the hall to the electrocardiographic department where he had to get undressed again for his EKG test. It would have been very easy for him to have left his clothes in the x-ray department locker room and go for the EKG in his bathrobe, thus having to get dressed once instead of twice. This sort of thing can easily be corrected but it is the kind of detail which is not generally known about unless careful attention is given to patient complaints.

complaints is to urge the employes to report all complaints. This requires a climate of approval for complaint-reporting and a broad understanding on the part of personnel as to the general purpose of getting these complaints. It is easy for this complaint-reporting to degenerate into merely a method of getting back at another department in the hospital or giving vent to personal antagonisms between employes. Nevertheless, we should develop a climate and an opportunity for employes to report complaints through their department heads so that complaints can be evaluated by the administration.

Probably the most difficult thing for any administrator is to avoid becoming defensive about complaints. It is natural for the administrator who has put so much effort and work into the development of the hospital to be sensitive about any criticisms. When the criticisms come, the administrator often develops an antagonistic feeling so that when a patient complains about the bill the immediate reaction may be to tell the patient how hard the administrator works to keep the costs down rather than to use this as an opportunity to explain the bill to the patient and tell him just what the various charges included, why they are high, and what he gets for the money he pays.

It is not easy to receive complaints with a judicious attitude and to establish a climate in which they are welcomed, but if we can accept the philosophy of a complaint's being an important tool for the improvement of patient care, then it will be easier for us to open the door to complaints and receive them in a way that can be productive.

If patient complaints are to be used as an educational tool and if criticism is to be passed on to personnel without disturbing working relationships, then it must be done on a routine and regular basis. A now-and-again or once a year discussion of complaints usually results in buck passing and trying to fix the blame on someone else. The objective should not be to fix blame, but rather to work out a better method so that there is not a repetition of the error. A regular and routine study of complaints develops a constructive philosophy and an understanding of the purpose by all concerned with patient welfare.

There should also be an understanding of the fact that many complaints arise out of the emotional aspects of the patient's illness. A complaint about the discourtesy of the cashier may stem from the patient's concern about his ability to meet an unexpected hospital bill but it is just as important for us to understand and handle this situation properly as it is to deal with the cashier who actually is discourteous. Patients are emotionally disturbed but this fact is not an excuse for complaints, it is merely another factor we need to consider in an educational program leading toward better total patient care. ■

The Modern Hospital of the Month

Linear Design Makes Each Wing a Hospital

Seven wings built around a central court give the new Fisher-Titus Memorial Hospital at Norwalk, Ohio, described on this and succeeding pages, the general appearance and "feel" of a handsome ranch-style home rather than an institution. Each wing of the 100 bed hospital, in effect, is a complete, special hospital, able to function independently of the others. The wings are connected by spacious corridors.

Below: View of the central garden court, completely surrounded by windows, which provides the focal point for the hospital.

THE CENTRAL COURT IS FOCUS OF ATTENTION IN THIS ONE-STORY PLAN

THE one-story, "linear" design of the new Fisher-Titus Memorial Hospital at Norwalk, Ohio, is believed by its creators to serve the patients well in two ways: It makes them feel comfortable and more at home than is possible in the traditional hospital, and it facilitates the smooth, efficient flow of equipment, supplies and personnel, and even the patients themselves. For example, a patient can be delivered by ambulance directly to the emergency room and if x-rays are needed he can be wheeled across the corridor without being moved from his stretcher.

Patients admitted for regular surgery recuperate in their own special wing which has accommodations for 31. Included in this area are a lounge and complete substation facilities to serve the surgical patients.

Another separate wing has beds for 20 maternity patients. New mothers and their infants are not required to come in contact with other patients.

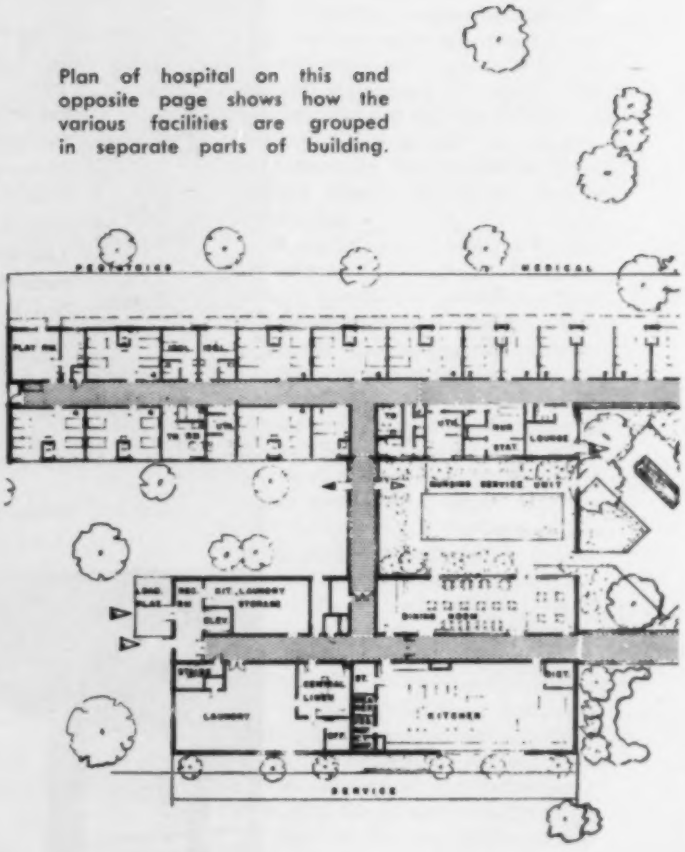
Beds for 35 medical patients are immediately adjacent to the garden court. A corridor acts as a buffer against street noise, and, as added protection, sound conditioning materials are used throughout the hospital.

Entirely separate from the rest of the hospital is the wing containing the kitchen, laundry and maintenance sections with their mechanized facilities. The hospital cafeteria has one complete glass wall overlooking the garden. Administrative offices are grouped around the paneled central lobby which is reached by covered walkways.

(*Text Continued on Page* 81)

Architects for the hospital were H. E. Beyster & Associates, Inc., Detroit. John T. Hilberg was the chief designer and Allen Mather was hospital consultant for the architects. Justin W. Greene is administrator of the hospital.

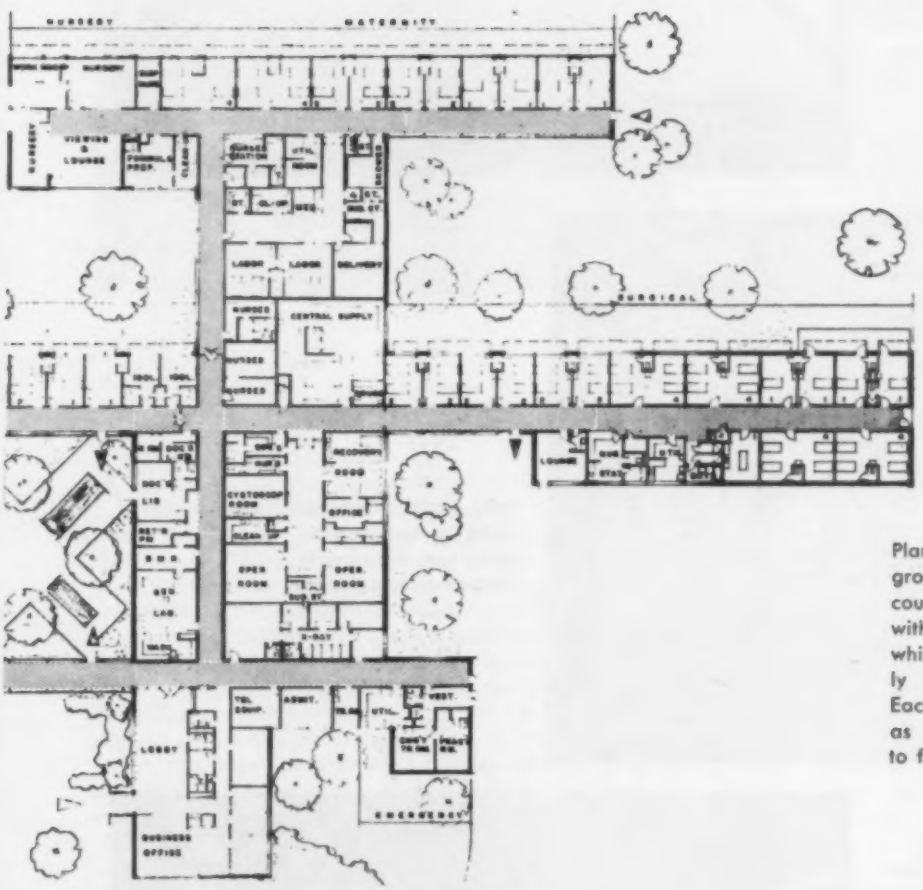
Plan of hospital on this and opposite page shows how the various facilities are grouped in separate parts of building.



The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital and the architects. A similar award will be made each month.

OUTLINE OF CONSTRUCTION COSTS

Total project cost		$1,484,011.00
No. of beds	100	
Cost per bed		14,840.00
Total square feet	62,400	
Square feet per bed	624	
Cost per square foot		21.77
Total cubic feet	788,800	
Cubic feet per bed	7,888	
Cost per cubic foot		1.67



Plan shows seven wings grouped around central court and interconnected with spacious corridors, which are lighted naturally by full-length sash. Each wing is organized as a self-contained unit to function independently.

Right: Aerial view of hospital shows linear design, like that of modern "ranch" house.

Right: Covered walkway leads to paneled lobby, surrounded by administrative offices.

Left: Paneled central lobby is furnished to carry out functionally modern building plan.

Right: Rooms are decorated in pastel tints. The adjustable beds are operated by power.

LABOR SAVING DEVICES MAKE THIS HOSPITAL ECONOMICALLY PRACTICAL

ALL the comforts and conveniences of modern living should be incorporated in a hospital, planners of Fisher-Titus Memorial Hospital contend. And so they included as many as possible – beginning with the 17 acres of landscaped grounds and the garden court where patients and personnel are invited to relax in the sunshine.

Indoors, the relaxed atmosphere is maintained by large window areas oriented to the south, cheerful colors, and attractive furnishings. The largest rooms contain only four beds. Single rooms have their own terraces where patients may step outside to sun in privacy.

The latest labor-saving devices make the single-floor plan as economically practical as it is convenient, the architects and engineers point out.

Each room has outlets for telephone and television, the latter connected to a central roof aerial. Also provided in each room are individual air conditioning controls and two-way communication system with the nurses' station.

A special feature of the maternity wing is a lounge where prospective fathers can wait in air conditioned comfort. Two walls of the room serve as viewing windows into the nursery so that fathers can while away the time admiring other people's babies until their own are brought in.

The 14 bed pediatrics unit includes a playroom decorated in highly imaginative fashion and offering such attractions as a television set and a private patio. ■

Far left: Fathers' waiting room with windows to nursery. Below: Playroom in the pediatrics unit.

Above, center: Cafeteria windows overlook garden. Above: Nurses' station is well arranged.

Surgeons Hear Reports on Antibiotic Use, Graduate Training, Shortage of Physicians

CHICAGO. – The extent to which antibiotics are used unnecessarily for surgical patients, contributing to the development of resistant strains of staphylococci and adding to the cost of hospital care, was suggested in a report presented here last month at the 44th annual Clinical Congress of the American College of Surgeons.

Dr. Robert S. Myers, assistant director of the College, said a study of herniorrhaphy patients in 24 community hospitals demonstrated that far too many of these patients are receiving antibiotics prophylactically, and the particular antibiotics used are frequently without therapeutic value against the staphylococci found in hospital infections.

More than 11,500 surgeons and visitors attended the Congress, which presented a five-day program of lectures, postgraduate courses, scientific exhibits, research reports, surgical motion pictures, and televised surgical demonstrations. Operations were televised at Passavant Memorial Hospital, while surgeons in the television audience at a downtown hotel followed the procedures on large, color TV screens and, by means of two-way, closed-circuit TV, asked questions of the operating surgeons and listened to discussions of the operations conducted by consultants.

When Not To Use Antibiotics

The study reported by Dr. Myers indicated that prophylactic use of antibiotics following uncomplicated inguinal herniorrhaphy varied from routine use in most cases in one or two of the hospitals studied to little or no use in other hospitals. Examination of the records in all the hospitals showed that the rate of infection among those receiving antibiotics was three times higher than in the group which did not receive antibiotics, Dr. Myers told the Congress.

In addition to its demonstrated lack of value in preventing infections, Dr. Myers added, the prophylactic use of antibiotics following herniorrhaphy is a needless expense. "From our experience in this particular study," he reported, "the amount of money wasted for the unnecessary use of these drugs and the wasted hours in administering them, if projected to more than 5000 general hospitals in the United States, would amount to $247,000 and 25,000 wasted nurse hours."

Few Free Patients Left

Proper training of surgical residents in hospitals is threatened by the gradual disappearance of the service patient from hospital wards, a group of surgeons agreed during a panel discussion on graduate training. The rapid spread of hospitalization and surgical prepayment plans and the growing number of surgical residencies have combined to make the problem acute, Drs. Warren H. Cole of the University of Illinois, Stanley O. Hoerr of Cleveland Clinic and Harold A. Zintel of Columbia University College of Physicians and Surgeons, New York City, agreed.

"We are caught by social trends which are interfering very seriously with the education of surgeons," said Dr. Hoerr.

"Something has got to give somewhere, since the free service patient is disappearing and we are not allowed to use any other patients for the purpose of teaching surgery," Dr. Zintel warned.

The nearest thing to an answer that emerged during the discussion was suggested by a lawyer, Lawrence Howe Jr. of Chicago, attorney for the College, who said that education of the public as to the need for training surgeons and as to the competence of senior residents would eventually make possible the widespread use of private patients in surgical teaching.

Discussing the legal problems involved in the use of private patients for graduate training, Mr. Howe pointed out that courts have ruled certain tasks may be delegated by the surgeon to a resident. In one case, a court considered delegation of a diagnostic procedure "justifiable," Mr. Howe reported. Within the operating room, however, courts have generally held that the surgeon is fully responsible. Participation by the resident in an operation "goes to the heart of the relationship of the patient to his doctor," and the "contract of consent" may be violated if the resident performs the surgery, he said.

A written consent from the patient to have the resident perform the operation is considered adequate protection for the surgeon, Mr. Howe stated, although patients have been known to claim they did not know what they were doing when they gave consent.

Appointment of an advisory committee on medical education to the U.S. Public Health Service was announced to the Congress by Surgeon-General Leroy E. Burney, who said the committee would seek an answer to the question: "How shall the nation be supplied with adequate numbers of well qualified physicians?"

"The truth of the matter is that we in the United States are falling behind in the race for medical manpower, month after month and year after year," Dr. Burney said. He rejected the argument of many medical authorities that there is no real shortage, but only maldistribution, of physicians.

"The problem of providing adequate numbers of physicians is more than a problem of geographic distribution," he declared. "We know there are unmet needs. They are presented to us by individual research institutions, medical schools, hospitals, state and local governments, health agencies and industries. We know that our concern is shared by the health professions, leaders in education, and the public."

There is general agreement that the present ratio of 132 physicians to 100,000 population should not be allowed to drop below that level, Dr. Burney said. Some have contended that proportionally fewer physicians will be needed as new methods of diagnosis and treatment are developed, he acknowledged. "Others hold that every major medical advance has been followed by increased demands for physicians," he added.

Intern Shortage Acute

"A most urgent need is the existence of some 14,000 approved internships in American hospitals – twice as many positions as the number of medical graduates being produced," Dr. Burney concluded. "Other needs for physicians have arisen from the development of hospitals, particularly general hospitals, in the past 10 years; the rapid growth of voluntary insurance plans; rapid changes in medical and surgical technics, and greater utilization of hospitals."

In another major address to the

(*Continued on Page* 162)

Principles Are More Important Than Money

Important as money is to any hospital, there are higher and more important issues to be considered than financial ones, and the hospital that solves its financial problems by good administrative methods is better than one that is governed solely on the basis of financial considerations

S. G. Hill

IT IS an open question, depending to a great extent upon the point of view, whether finance is to be regarded as an aspect of administration, or whether it is to be regarded as something quite separate from administration. Leaving aside the vested interests involved in this question and ignoring also the particular structure of some administrative enterprises which appear to divorce finance from the mainstream of administration, it is contended that the better view is to regard finance as an aspect of administration, and an extremely important one at that. If the view is taken that administration is not a narrow skill but involves the coordination of personnel, legal, technical and similar questions, then surely financial questions must also be included in this list and, no matter what particular administrative structure is employed, finance must be regarded as an aspect of administration and not as something quite separate.

What part, then, should finance play in administration? How should it be integrated with the other aspects and administrative factors? The answer to these questions must depend largely upon the nature of the particular enterprise. Financial patterns vary so greatly that general principles are more than ordinarily difficult to adduce. However, if we examine the general nature of financial factors in administration, certain general principles may well emerge.

For a simple start, we may assume that every administrative enterprise requires finance of some nature from some source. In the case of hospitals, finance may be derived from the patients themselves, from insurance schemes, from endowments and charitable bequests or from a beneficent government, but no matter from whence it comes, money (be it dollars, pounds or rubles) is essential to the enterprise.

From this somewhat obvious starting point, we may proceed to a related factor. This one, although not quite so universally true as the first, is sufficiently true for it to be accepted and exceptions ignored. This second truth is that available money is always, comparatively speaking, in short supply. In other words, there is never enough money to do all that could be done, given virtually unlimited resources. It is a very short jump from here to the next step, which is that spending must always be, in practice, a matter of priority and competition between various claims upon limited available funds.

Again, it is a short and logical step farther which indicates that in order to ensure that the best possible value is obtained for limited money, waste and unnecessary expenditure shall be ruthlessly eliminated so that every pound, dollar or ruble is used as effectively as possible.

The tight and familiar financial circle is now almost closed with the fifth factor, whereby economy and financial control are widely employed to ensure that value for money is obtained.

It is suggested that these five quite distinct though closely related principles apply to the financial operations of all administrative enterprises, and the uniformity of these principles is, in fact, more significant than the wide divergencies between methods of fund raising. These, as we know, vary from completely free enterprise at one end of the scale to entire support from government expenditure at the other end of the scale. Differences there will certainly be between organizations of these types and some of these differences will be referred to later, but the five principles enunciated are equally valid for all types of financial patterns and so we will examine in more detail their application to administrative organizations.

Principles one and two are closely related and may be dealt with together. Money is essential and the supply of money always falls short of demand. Money is the lifeblood of the enterprise and there is never enough of it. Surely then, it may be contended that financial matters must be absolute and dominating within the enterprise. There will be many people on both sides of the Atlantic who hold that simple view and the weight of such an argument cannot be gainsaid. It is not, however, in all circumstances completely true, and still less true are some of the implications which are often too readily assumed to flow from

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This is third in Mr. Hill's series of articles on general principles of administration. The first two articles appeared in the September and October issues of The MODERN HOSPITAL. Other articles in the series will appear in forthcoming issues.

the thesis. The most common manifestation of the doctrine of "financial absolutism" is the contention that no matter how badly one needs to expend money on a given project, if the money is not available, it cannot be spent and so the project must fail. This doctrine implies that all administration must be dominated by the money available rather than by the needs of the enterprise. Of course, administration seeks to bring these two factors as closely together as possible, but where there is divergence, the financial absolutists say that there is no room for argument or discussion and the only criterion is the amount of money available.

Doctrine Is Not Acceptable

This doctrine is far from being acceptable, particularly as applied to hospitals. In the first place, although we have assumed the supply of money (from no matter what source) to be a definite, more or less unalterable, figure, this is in practice not quite true, and if a project is vital enough, there are surely few circumstances in which the supply of money could not be increased to meet it. If, for example, some expensive new drug were to become available, it is difficult to believe that patients would be permitted to die simply because the money necessary to purchase that drug was not immediately available. Certainly in Britain, with its national hospital system, no government, however hard up, could possibly withstand the pressure of public opinion in a matter of this nature and the necessary money would just have to be found from somewhere. Obviously one could speak with much less authority of the United States hospitals where, it is understood, more individual financial liability falls upon the patient, but in such a system it is equally difficult to imagine that lives could knowingly and needlessly be lost solely because of financial limitations.

This somewhat harrowing possibility has been mentioned with the sole object of illustrating that cases, however exceptional, can exist when the supply of money available to an enterprise is no longer regarded as completely unalterable and special steps are taken to increase the supply, thus refuting the doctrine of the financial absolutists to the effect that, in all circumstances, the administrative operations of an enterprise are governed absolutely by the amount of money available. Exceptions based upon extreme considerations of life and death are easy to understand but of extremely limited applicability, and so, even if we admit that in exceptional cases the supply of money may be increased where considerations of life and death are involved, we are not much further forward in practice. The important point, however, is that there should be *some* exception to the principle of financial absolutism.

Once this exception is demonstrated and admitted, then one may say in general terms that steps may be taken to increase the supply of money provided the urgency of the matter is great enough. Whether or not the urgency in any given case is great enough to justify such exceptional steps is an administrative and not a purely financial decision. This is really another way of saying that it is for administration to choose whether or not it will be bound by the supply of money normally available to it and, if it chooses not to be so bound, it will consider what steps should be taken to increase the supply of money. This view is administratively tenable, quite practicable, and solves the problem which arises if management, instead of controlling and administering an enterprise, is at every point dominated by purely financial considerations.

Increases in the supply of money, whether from government or other sources, are obviously exceptional and much administrative freedom of action would be lost if this were the only device for dealing with financial matters which do not fit neatly into the accepted pattern. There are, however, other methods.

Can Take the Responsibility

First, there is the quite simple device of taking responsibility for the consequences of overspending. It is for the financial adviser of an organization to say, "If you embark upon such and such a project, you will overspend," but it is for the administrator to rejoin if he thinks fit, "I accept that fact and I will take responsibility for the overspending." How such an overspending will be dealt with and what the responsibility would amount to are not matters which are relevant to the present discussion and would vary with the type of organization, but the point is that the brief conversation quoted is considerably removed from a flat statement by the financial adviser that such and such a project *cannot be* embarked upon *because* there is no money available.

Second, a warning that a certain project cannot be embarked upon because it cannot be afforded must be seen against its proper background. It may be assumed that most organizations operate upon some sort of preestimate or budgetary system, and this means that a given hospital may estimate its total expenditure for the year to amount to $1 million, of which $650,000 will be spent in salaries, so much on drugs, so much on provisions, and so on. It is also assumed that it has been estimated that an income of $1 million will be available to meet the cost.

Should Add — "Assuming - -"

Against this background, if a financial adviser says that a certain project cannot be afforded, he should really add, "assuming that all my estimates and calculations were accurate and that administrative operations turn out in practice exactly as planned and provided for." These are important words indeed, though they are nearly always overlooked when this type of financial advice is being given. This is a pity because it cannot be expected that expenditure will turn out exactly as forecast and there is always a tendency to allow for contingencies, but even if estimates agree absolutely with actual expenditure, it is still open to the administrator to say that he will go ahead with the proposed project and will modify other expenditure, so that the necessary money will be available.

Upon the fundamental question then, it is contended that although money is essential to administrative enterprise and although there is never enough of it, nevertheless money should never be more than an important factor in administration and should never be permitted to dominate the administrative operation.

Our third common factor of all administrative organizations is the fact that all expenditures are essentially in competition with each other and, accordingly, a constant system of priorities must determine financial operations. This aspect of affairs is well understood and is a familiar feature of our daily lives. An expensive vacation means less money for other forms of entertainment; a new suit may mean that the purchase of a new overcoat must be deferred. So it is with hospital administration. An expensive new piece of apparatus might well mean

that renewal of plant and equipment has to be postponed. If we choose to provide our patients with highly expensive food, this may have to be at the expense of our standard of maintenance and decoration, our system of records or engineering services. It is quite certain that we cannot provide the best in every direction all the time, and the continuing series of decisions regarding priorities is one of the most important aspects of administration. There are endless permutations: Article A may be purchased instead of article B; the purchase of article A may be deferred; article A may be purchased but in an inferior quality at a lower cost; the dietary may be improved or modified, permanently or temporarily, and this may be done by altering the items in the dietary, altering the quality of items, or altering the quantity of items; maintenance work may be deferred or even anticipated, and quality of paintwork or building maintenance may be set at a high or not so high standard.

The possibilities of influencing expenditure upon salaries and wages are considerable. In England it is neither practicable nor in accordance with public policy that hospital staffs should be employed and dismissed according to the financial climate and, of course, no hospital anywhere has staff whose services are not really required, but the turnover of hospital staffs is fairly high and, if money is needed badly enough, a certain judicious delay in filling a number of appointments will soon accumulate a respectable sum of money. Indeed, if the shoe pinches hard enough, hospitals might well find that they must just learn to do without a porter, a clerk, a cleaner, a laundry hand or, for that matter, staff employed on duties more directly relevant to the care of the patient. There will be inconvenience and perhaps some disorganization, but the hospital will not collapse and, after all, the objective of finding additional money is being achieved to compensate for the inconvenience.

It is to be emphasized that these endless possibilities are always open to the administrator and that the decisions to be made are administrative and not financial ones. A realization of this room for maneuver should always be in the administrator's mind and it often makes nonsense of the doctrine that such and such a thing cannot be done because "there isn't the money for it." In almost all circumstances there is the money for it if one is prepared to use a little ingenuity.

The fourth common factor was the elimination of waste and there should be little difficulty in agreeing that this is in any circumstances a good thing to do. It becomes a prudent and, indeed, a necessary thing to do in circumstances of comparative financial shortage. One or two considerations must, however, be examined even in such an obvious and noncontroversial field as this.

First, one must be clear as to what is meant by "waste." If we accept a simple working definition that by wasted money we mean money which need not have been spent and which makes no adequate contribution to the operation, we have still not arrived at an absolute definition because in some cases, at least, we would have to say "money which need not have been spent, *in whose opinion?*" It happens that most of the "waste" of which hospitals and public authorities generally are accused falls in this area, and we should be careful to note that it is not strictly "waste" at all. A hospital might be criticized for putting up what appears to be an unnecessarily expensive building, but those who criticize the expense of the original structure may not realize that this particular building is much more durable and more easily maintained, so that after a period of 30 years it will, in fact, show a profit against a building of cheaper original construction.

There is a tendency for all medical specialties to hold a private, though not always unexpressed, opinion regarding the money "wasted" by other specialties and, incidentally, the much higher value which would be received for that amount of money devoted to their own specialty. Physicians are not always wildly enthusiastic regarding the money devoted to psychiatry; on the other hand, psychiatrists will tell us that if they had a more rational share of available money and resources, much physical ill health could be prevented. And so it goes on.

Our final common factor, the need for economy and control of expenditure, again opens up endless possibilities, many of them depending upon particular interpretations. Economy is like peace: Everyone is in favor of it — his own particular brand, of course, and on his own terms. This is not the time or the place to discuss in detail whether economy really means

(*Continued on Page* 155)

One Man's Waste Is Another Man's Necessity

WE MUST ignore various types of alleged waste in purely financial considerations and concentrate upon true waste, such as overordering of supplies, uneconomic use of materials, deficiencies in services and utilities, and irrational employment of staff. These are all matters to which the administrator should give considerable attention, in the knowledge that anything he can save in these fields will facilitate his administrative operations in more important endeavors.

The word of warning which must be uttered in this context is that although one may constantly seek to reduce and eliminate waste, it must be recognized that the tendency to waste (or rather to employ insufficient care with the use of materials and services which belong to others) is inherent in human nature, and the administrator deludes himself who believes that he will one day find himself with a staff that will not waste anything. Therefore, in this field, devices are of perhaps greater value than exhortations. It is, on the whole, easier and cheaper to install a light that automatically switches off when not required than to depend upon some 20 or 30 people remembering always to switch off that light when they do not need it. Administratively, this adds up to the proposition that within every administrative organization there is a wastage norm of X per cent. Anything over X per cent should meet with reasonable administrative efforts to reduce it. Anything under X per cent is good provided that the administrative output to bring about this result is not uneconomic. The administrator who seeks to reduce X per cent to 0 per cent is heading straight for the psychiatrist and an early grave. ■

EXHIBITS AT HURLEY HOSPITAL FAIR

A printed guide to exhibits was presented as each person registered, thereby eliminating the necessity of conducting guided tours. Following is description of each exhibit:

Labor and Delivery
Labor room setup. Identification and immediate postnatal care of the newborn.

Postpartum
Rooming-in unit with the new family getting acquainted. Demonstration of the classes given to new mothers in the care of the newborn. Isolette used in the premature nursery.

Anesthesia and Operating Room
An O.R. table, showing the anesthetist with her inhalation equipment; the surgical nurse wearing the proper type of wearing apparel in the O.R.; and display of solutions used for cleansing and sterilizing.

Recovery Room
Display of the features of the postanesthesia cart and immediate postoperative care

Surgical Floors
Patient with chest drainage, colostomy care. Anesthesia unit prepared for patient returning from operating room.

Medical Floors
Patient in oxygen tent with suction equipment, bed rails, receiving Barron feeding. Patient in croup tent, having postural drainage, receiving aerosol inhalation. Correct use of medicine carts showing different medications. Display of Orinase and Insulin for diabetic cases.

Psychiatry
Display of electro-sleep therapy equipment.

Pediatrics
Child with restraints receiving I.V. and cold steam. Equipment used in performing sweat test for diagnosis of cystic fibrosis.

Dietary
Foods essential to good nutrition, with food models demonstrating these groups. Preparation of food for the Barron Food Pump. The egg — its history — its use as a food — its use as a medicine.

They came to the fair to

WHAT began as a modest project to acquaint its staff with procedure changes at Hurley Hospital in Flint, Mich., grew into an effective and inexpensive "Procedure Fair" that attracted more than 1800 visitors. The five-day event highlighted the hospital's observance of National Hospital Week and marked the beginning of its 50th anniversary celebration.

The idea of presenting the procedure fair originated with a member of our staff education committee, which is composed of two clinical instructors in the school of nursing, two head nurses, a nursing service instructor, and the director of nursing service. Appointed by the chairman of the Nursing Education Organization (a group of professional nurses delegated to integrate and coordinate the nursing school and the nursing service), the staff education committee is responsible for the continuing education of nursing personnel.

Because of several revisions in the procedure manual, and the large number of newly established procedures recently adopted by the procedures committee, the members of the staff education committee readily agreed that the simplest method of acquainting the nursing personnel with these procedures was by visual demonstration.

The procedures committee was therefore requested to prepare a list

This article was prepared by the following members of the staff of Hurley Hospital, Flint, Mich.: Eleanor Poole, R.N., department of nursing; Gayle Kinder, public relations department, and Robert E. White, director of employe and public relations.

Exhibit showing complete surgical layout for operation. Mannequins, borrowed from store, add to realism.

Member of the hospital's clerical staff examines new rooming-in unit. Chart explains features of the plan.

learn about their hospital

of new and revised procedures which it would like to have presented. The staff education committee then selected the departments that would participate in the fair, and made the necessary arrangements with each department head. Twenty-two departments accepted the invitation to participate. Each member of the committee was assigned several departments. They worked closely with each one, discussing ideas for the exhibits and offering assistance wherever needed.

Early in the planning of the fair, it was apparent that general employes would be as interested in the exhibit as the professional nursing staff would. After consultation with the public relations department and the administration of the hospital, it was decided the fair would be presented during National Hospital Week in the hospital's cafeteria, which would provide more floor space for displays and would be easily accessible to the employes, the medical staff, and hospital visitors. It was also felt this was an excellent means of calling public attention to Hurley Hospital's golden anniversary year celebration which officially opened on May 12, National Hospital Day, with the issuing of a proclamation by the mayor of Flint.

The success of the fair can be attributed to the ingenuity of the departments, each of which made use of materials on hand and the talents of everyone including students, nurse's aides, registered nurses, clerical employes, and others. The maintenance and housekeeping departments were

A clinical instructor in obstetrics explains equipment and procedure used in labor and delivery rooms.

Instructor operates rocking bed as student learns how patient feels in it. Student nurses set up the display.

EXHIBITS AT HURLEY HOSPITAL FAIR

Pharmacy
Requisition forms used in pharmacy. Display of new tube system. Narcotic and barbiturate counters.

Central Supply
Display of the Bennett pressure machine. The amount of equipment damaged beyond use during one month.

X-Ray
X-ray films of various diagnostic examinations showing the result of good preparation and poor preparation of the patient.

Laboratory
The technics used to isolate and identify harmful bacteria.

Isolation
Demonstration of isolation technic in parts of the hospital other than the isolation unit.

Emergency
Emergency treatment in the areas of bandaging, lavaging, tetanus antitoxin.

Physical Therapy
Display of physical therapy exercises, and equipment used in this department.

Admitting
Display and explanation of the new admitting forms. Procedure followed on deceased patient.

Medical Records
Display of the correct chart form as it goes into storage. The work of the department in statistics and research.

Safety
Display of fire extinguisher equipment. Explanation of the hospital fire signal system.

Personnel
Procedure followed in the hiring of a new employe.

Public Relations
Procedure followed in the handling of news release on a hospital patient whose admission is of interest to the news agencies. Activities of the public relations department.

Nursing Arts
Demonstration of use of the respirator and the rocking bed. Display of protective comfort devices, positioning, bandaging, and other fundamental nursing procedures.

especially cooperative, and played a most important part in moving equipment to the cafeteria and setting up many displays. The cafeteria manager was extremely helpful in providing tables, chairs and the necessary floor space. Posters and signs were made by individual employes, and the cost of materials purchased for use in the fair totaled less than $10. Local department stores graciously lent us their mannequins. The Clara Elizabeth Fund for Maternal Health provided birth models for the labor and delivery exhibit, and the Michigan Medical Service (Blue Shield) and pharmaceutical companies also provided exhibits in keeping with the educational and anniversary theme.

As the fair began to take shape, a floor plan was drawn to be used as an aid in assigning floor space to each exhibit. The 22 displays were spaced along the walls completely surrounding the cafeteria. Ample eating space remained in the center area for more than 400 people.

The local radio stations included announcements of the procedure fair in their newscasts and followed them with spot announcements throughout the day. The local television station took motion pictures of the fair which were shown on its newscast, and the newspaper was most cooperative in running special feature stories telling about the fair.

Originally scheduled to run only two days, the fair was extended an additional three days as a result of popular demand. A great many employes and members of our medical staff returned a second time with their families. One employe remarked as she completed her tour of the exhibits, "I have learned more here today about the entire hospital and the relationship of all departments than I have during the 18 years I have worked at Hurley."

One notable fact evidenced was the spirit of enthusiasm with which our personnel entered into preparing their exhibits, and which prevailed throughout the entire fair.

It is the feeling of our staff education committee that the procedure fair was highly successful in creating employe interest and depicting the overall operation of the hospital, but most of all, it accomplished its goal of informing the nursing staff of the new procedures.

Also, the public relations department and the administration of the hospital feel this was a splendid means of "telling the hospital's story" not only by explaining the complex organization of the hospital, but also by telling it in a manner which was both meaningful and dramatic. This technic by itself created the extensive public interest which is evidenced by the attendance at the fair.

To say that we were completely satisfied with the response and results of the fair does not sufficiently emphasize the value we have placed on it. Our belief in the positive value from both a public relations and educational point of view reached its climax upon receipt of this most delightful letter from a 9 year old visitor to the fair:

"Dear Sir:

"Today I visited your hospital. I enjoyed my visit very much. I learned many new things. The things I learned most about were, the kinds of medicine a person would take, all the tools a doctor would use in an operation, the machine which changes invisible waves to visible when it touches oil or water, and the tools the doctors used years ago.

Sincerely yours," ■

Top: Practical nurse and nurse's aide examine a display by medical units showing how a patient receives oxygen therapy. Above: Display by the x-ray department emphasizes importance of proper preparation of patients before x-ray tests and illustrates faults due to lack of planning.

What supervisor's responsibilities are and his relationships with other people is the subject of this conference on

How To Teach Supervisors How To Supervise

Leonard Nadler

INASMUCH as supervision is essentially a matter of getting work accomplished through the efforts of other people, the supervisor must take a look at his relations to the other people who are part of the broad hospital community. He must examine his responsibilities as a supervisor to the various individuals and groups who are a part of that community.

The supervisor's responsibilities can arise from the very nature of his profession, by law, or from tradition. No matter what the source, it should be written down in the job description covering his position. His responsibilities toward others must be constantly enumerated and weighed. Some of these responsibilities will be the same in words, although different when actually carried out in relation to the varying segments of the hospital community.

In the supervisory training conferences, after the members of the group have explored the organizational structure of the hospital and established the chain of command, the next session should be devoted to looking at the supervisor in relation to other people and examining supervisory responsibilities. The focus of this session should be broad rather than specific. At a later point in the training program it would be advisable to probe into specific job responsibilities. At this meeting, however, the concern should be more with developing a broad concept of the responsibilities of the supervisor. (*Continued on Page* 90)

Mr. Nadler is chief of the training division in the bureau of personnel, Pennsylvania Department of Public Welfare, Harrisburg. This is the third in Mr. Nadler's series of articles on training supervisors. The first two appeared in the September and October issues of The Modern Hospital. The fourth article will be presented next month.

Getting the Job Done Through the Efforts of Others Is Supervision

(*Continued From Page* 89)

"What is supervision" is a question it might be well to ask of the training group at the outset. Don't expect agreement, particularly if the group members come from different hospital disciplines; they will try to define the word in terms of their own discipline. While no generalization is intended, the question might evoke this kind of response:

***Nurse*: Taking care of a ward.**

***Pharmacist*: Being in charge of pharmacy.**

At one conference, this question was asked of each participant and similar replies were given by each. All of them were concerned with physical things or jobs. The session leader became worried, as this was not what was suggested in his resource material. He changed the line of questioning and asked: "What does a supervisor do?" The almost unanimous response was—"Get blamed for everything that goes wrong!"

Though taken back by this chorus response, he tried to probe it. "Why," he asked, "do things go wrong?"

The group thought this was pretty obvious. "Look," said one member, "if I could do everything myself things would be different. Sure I'd make mistakes, but they would be my mistakes."

"Exactly," chimes in a nurse. "Some of these bright new R.N.'s act as if they had never been on a ward. I don't know what they're teaching them in nursing schools these days. Sometimes, I just don't seem able to get things done on my ward, unless I do it myself. Goodness knows, I can't be all over the ward every minute."

The leader picked up this point. "Your first concern, then, appears to be to get the job done. In your case, it's direct patient care. How about the rest of you, would you agree that getting the job done is one of the objectives of supervision?"

"No question," contributed the head housekeeper. "When admitting office notifies us that a room is to be vacated, we've got to get it stripped, cleaned and made ready for the next patient. But this is the concern of everybody in housekeeping. Are you saying that all my people are supervisors?"

"I don't think he's saying that at all," said the lady from food service. "All of us are concerned with getting the work done. But, some of us do the work while others give the orders. You know, like Indians and chiefs." The group broke into laughter because the current joke going the rounds was the one about too many chiefs and not enough Indians.

"It looks as if the title of chief or supervisor really isn't important," summarized the leader. "The point appears to be that some employes get the work done by doing it themselves. Others get it done through the efforts of others. So, I guess that getting the job done through the efforts of others is supervision."

At this point, there seemed to be general agreement. A few minutes later one of the nurses began talking about supervisors. "Supervisors are just a different breed of people. Some supervisors don't seem to have any respect for their employes. If they. . . ."

"Just a minute," interrupted another nurse, "what do you mean 'they.' Aren't you a supervisor?"

"Me!?!" came the shocked response. "Why I'm only a head nurse!"

For several minutes confusion reigned. Everybody was talking at once. Slowly, the group calmed down and began talking the point through. In this hospital, as in many others, nurses were designated by titles such as Supervising Nurse, Head Nurse, Chief Nurse. There seemed to be general agreement in nursing service as to what these stood for. However, somewhere along the way the titles became so rigid that only those with "supervising" in the title were considered supervisors. The group was quite willing to reassess this against the definition it had just evolved.

In the course of observing many of these training conferences, the confusion of titles has become apparent. Maybe some day, there will be general agreement on titles so that everybody will know where he and others stand in relation to each other. Some think that this might be helpful, particularly since there is movement of personnel from one hospital to another and from one section of the country to another.

There are others who tend to think that urging uniformity of titles calls for too much compulsive behavior. Rather, they think that titles should be left alone. Each hospital should decide for itself what titles to use and how to use them in practice.

Supervisors Need To Learn To See Themselves as Supervisors

It makes no difference which school of thought you come from. What is important is that, at this time, all the members of the training group come to some kind of understanding of titles. If they are not too meaningful in the regular work situation, they should not be used as guides during the training sessions. The need for clarification of titles might well be one of the items referred to administration for further study.

Training groups, as is true of other human endeavors, have a history all their own. This series of articles is based on observations of many groups. It would be misleading to suggest that all groups come to the level of verbalization indicated earlier. Some groups do reach this stage quite early; others take longer to develop. Researchers are still trying to analyze the workings of small groups.

Experience has indicated that the early topics in the

training sequence should be those to which all can make a contribution. Organization, it is hoped, is one of these. This topic, "Responsibilities," is another. Caution must be taken, however, to avoid discussing specific responsibilities. These will be explored in a later session. At this time, it is important to once again help them see themselves as supervisors. In this role, what responsibilities do they have to the various groups they come in contact with?

As supervisors, they meet many other people individually and in groups. Obvious as this may seem, some supervisors have a tendency to view their area of responsibilities as being very small. When asked: "To whom do supervisors in our hospital have responsibilities," first replies included:

To the patients (from a nurse)
To administration (from the business office)
To the public (from the receptionist)

These are all highly predictable responses. The function of this training experience is to broaden the horizon of just such people. I saw one conference leader suggest that they try to list all the kinds of people who might be included in their area of responsibility. After some discussion, with an admirable amount of compromising, they arrived at the following list:

Patients **— This includes all who come to the hospital for any kind of medical, surgical or psychiatric service.**

Public **— It was agreed that this did not include the patients, who were a separate category. Under this heading would be relatives, friends and the community in general who had any contact with the hospital, but not for service.**

Administration **— The hospital administrator or superintendent was the obvious person identified with this area of responsibility. However, it should also include the board of trustees, state government or other body under which the hospital operates.**

Subordinates **— At first there was some heated discussion about this word. There was no lack of agreement that it included those supervised by the supervisors represented in the training group. However, some felt that the word had a derogatory meaning. On the other side, some of the supervisors felt that being a buddy to everybody was fine, but it could be carried too far. Even in a democracy, there are those who are clothed with the mantle of authority (supervision) and the others were subordinate to them. Though not everybody was happy with the word, the group accepted it but with individual reservations.**

Other Supervisors **— Once this was discussed, it was felt this area of responsibility was basic to a hospital. Business Office (Purchasing) is responsible to Food Service to see that bills are paid so that suppliers will deliver on time. Food Service is responsible to Nursing to see that the food is correctly prepared and served when scheduled. The training group continued until almost all the departments of the hospital were involved.**

Agreement on the Relationship Between Responsibility and Duty Keeps the Training Session Moving Along

Some people prefer to start any group activity with definitions. At times, this approach has merit. For this topic, an early definition might be made between certain key words. This may not actually be defining the words as much as coming to agreement on their use and relationship.

During the earlier session, the group may have stubbed its verbal toe on "Duties and Responsibilities." The more zealous of the group members might then have rushed to their dictionaries. They come to the next session triumphantly waving a piece of paper on which they have copied the dictionary definitions. Depending on the dictionary they used, they may find varying degrees of overlap in the definitions. The group leader must steer away from who is right and who is wrong. The training sessions must be related to the work situation to be worth while. Rather than a discrete definition, the relationship of the words may be more important. Most groups will agree that:

Responsibility **is being accountable for something.**

Duty **is that act which is required to meet the responsibility.**

Agreement on these terms can go a long way toward moving the training session ahead. Too frequently, sessions get bogged down because of lack of agreement. The sensitive session leader should try to ascertain if there is a real difference of opinion on meaning. Sometimes, group members will use the definition of words to block the progress of the group. If it weren't definitions, it would be something else. Basically, the group member is blocking. In a future article, it may be possible to explore further the significance of such behavior in training groups.

The function of the session leader is to keep the meeting moving along. Once agreement has been achieved, it is necessary to investigate how one knows the source of his responsibilities. For some areas of responsibility there are laws. For others, the responsibilities have developed through tradition and are now commonly accepted.

No matter what the source, they should be carefully and specifically stated. During one training session, a group member asked, "But how do I know my responsibilities? Nobody ever told me. I came to work here as a physical therapist. Sure I know in general what my responsibilities

are, because that was part of my professional training."

The personnel director relaxed in his chair, puffed at his pipe, and said, "Don't you know that there is a job description covering your position? The very first section defines your job and sets forth your responsibilities."

As I listened to this exchange I realized a common failing in many of our personnel officers. They do a fine job of getting the responsibilities down on paper. However, many of the employes never get to see the piece of paper. I suggested to the session leader that for his next session he obtain a copy of the job description of each member of the group. True, it would have been better to have it for this session, but you never can predict all the situations that will arise in a conference. If I were now advising a session leader preparing for this session, I would suggest a meeting with his personnel director before the session. (The job descriptions will be used again, in more detail, during a later session on "Job Improvement.")

In Developing the Training Group, the Session Leader Can Utilize the Technics of Group Participation

There are many ways to examine the responsibilities of employes in hospitals. One fruitful approach is to examine the responsibilities of the supervisors in relation to other groups with whom they come in contact. Earlier in the session the group will have clarified these other groups. This can now be developed further. The question might be asked: "What are our responsibilities to each of these groups?"

At this point in the development of the training group, the session leader can utilize some of our learning on group participation. One effective method is to divide the larger training group (possibly 15) into smaller groups of four or five. This is referred to by many names, the commonest of which is "Buzz Groups." (See Page 93.) Members of each buzz group can be asked to explore the responsibilities they think they have to the group assigned to them.

As some of the hospital training groups are limited in size and time, the session leaders can make adjustments. For example, although five groups have been identified (patients, public, administration, subordinates, other supervisors) the session leader may choose to explore only three in detail. This also provides an opportunity for some discussion of responsibilities on the open floor so that all the group members have a clearer idea of what kind of responsibilities are being discussed at this time.

In one group, the leader asked, "What do you consider your responsibilities toward the patients?" As it was a medical, surgical hospital, general agreement was reached that it was to provide the best care possible. When the same question was asked in a mental hospital, the consensus was "to help our patients get well so they can return to the community." This was further qualified by some to include those who were not responding to current treatment including drug therapy. In these cases, the group felt its responsibility was to make the patient comfortable and his stay in the hospital as meaningful as possible.

Sometimes, a responsibility cannot be placed into a slot quite this easily. For example, when it was suggested that another responsibility to the patient was keeping his records confidential, there were those who took exception to this. It was agreed by some that this was a responsibility to the public, not the patient. Fortunately, most of the group did not choose sides. Instead, the members got everybody to agree that some responsibilities have implications for more than one group.

To help clarify what is meant by responsibilities, it is sometimes desirable to encourage discussion on "responsibilities to the public." Frequently, employes will respond by discussing recent incidents. If allowed to, the discussion might easily turn on "what's wrong with the public." Here, the session leader is tempted. Being an employe, he too has some pet gripes about some segment of the public or all of it. Why not let the training group have its day and take its verbal swings at the public?

A Sure Way To Get a Discussion Started Among the Group Is To Ask About Employe-Public Relations

Part of the session leader's function is to get discussion started. By asking for a discussion of employe-public relationships he has a sure starter. Everybody will have something to contribute.

This is the point where the session leader is faced with a challenge. True, his function is to get discussion started, but it should be discussion related to the topic. His function does not end with starting discussion, he must also see that it stays on the track. The topic for this session is not "what is wrong with the public." It isn't even the "responsibilities of the public to the supervisors in our hospital." This is the time he may have to encourage the group to return to the topic as stated earlier and the objectives laid down for the session.

Possibly, he may wish to indicate that one of the recommendations of the training group might be an open forum on the topic with both sides (if there are only two sides) being represented. (*Cont. on p.* 94)

Small-Group Sessions Stimulate Thinking

THE purpose of the so-called "Phillips 6-6" technic of breaking a large group into smaller ones is to provide each member of the training group with an opportunity to contribute verbally. Some of us find difficulty in speaking our thoughts in a group of more than five or six.

It is difficult to give exact numbers as to the best size for each group, but some general guides are available. It takes at least two to make a group, but the possibility of productive thinking is not very great. With three people there is the danger of the "two-in's one-out" condition. There is a tendency for two of the group to identify with each other. As this is best accomplished by excluding the third person, the group runs the danger of defeating its own purpose. It appears, therefore, that four would be the minimum desired for a successful buzz group. Experience has shown the six figure to be best. A maximum of eight is possible.

Don't Try "Thinking in Depth"

The task assigned to the buzz group is significant. There should be no attempt to obtain thinking in depth. Rather, the task should be one that can be accomplished with little or no prior preparation. It should be phrased so as to stimulate thinking. Each buzz group can be given its own problem or task, or all groups can be given the same.

In view of the task to be assigned, the *time* allotted to buzz groups should be correspondingly small. It is doubtful if less than five minutes will suffice. At the other extreme, more than 10 minutes will probably allow the enthusiasm of the group to wane.

Buzz groups can take many forms. Physically, they should move away from the conference table into smaller groups. One method is assigning buzz group membership on the basis of proximity. That is, those who are sitting near each other form the group. This is the easiest and quickest method. However, members of adult training groups are not usually assigned to specific seats. Therefore, they will have chosen their seats for a reason. Sometimes this is physical, such as not facing the light, facing a window, or being near a door. Other times, it is based on associating with "people I like, who think as I do, work where I do, or come to the training group with me." If the training session is intended to provide them with the opportunity of learning more about others on the hospital team, proximity should not be used for groups seated in this fashion.

At times, the session leader will have to designate the membership of each buzz group. He may do this for a variety of reasons. An obvious one is to avoid the clustering of similar individuals as previously described. At other times, he may wish to group people on the basis of their previous experiences, length of service in the hospital, similar shifts, or other significant factors. This should not be an arbitrary manipulation of people, but rather a carefully thought-out assigning based on creating productive buzz groups.

The other extreme is to allow free choice. This permits the individual members to group up in any manner they choose. The danger is in loss of time in moving about the room. There is also the possibility of a proximity type of group resulting, with the hazards already noted. The free choice has some benefits, however, in allowing the group members to get together with those they think have similar problems. The free choice is most applicable where each group would have a different task.

Leader's Role Is Significant

If it is decided to use this technic, the *role of the conference leader* is extremely significant and he must make many advance preparations. The physical facilities must be arranged so that dividing into groups is possible. If the room is too small, the "buzzing" might prove overwhelming, with the result that nobody is comfortable or productive. The task chosen for the groups must be clearly formulated. If possible, it should be written on the blackboard or handed to the groups in a one-sentence question. The leader may also have to plan the membership of each buzz group if this seems desirable. Before the buzz groups are formed, the leader must prepare them for the experience. He must assure himself that the group understands the task and that the technic has a possibility of success.

Once the buzz groups have been formed, some conference leaders sit back to read, write letters, check attendance, or do similar chores. This is dangerous, for during the buzzing, the group will still look to him for leadership. If he appears disinterested, why should they knock themselves out? Once the buzz groups are formed, the leader should visit each group, spending less than a minute with each group. During this time, he should assure himself that they have understood the task. If not, he might ask one or two well chosen questions. Under no circumstances should he get involved in the group by answering too many of their questions or becoming involved in cross discussion. It is their thinking that is wanted.

While visiting the groups, he should watch the time. If five minutes have been allowed, he should watch the clock and, after four minutes, announce in a loud clear voice, "One minute to go." At the end of five minutes, the group leader should ask the group to join around the conference table as before. He must set an example by sitting down at the conference table and looking sincerely interested in hearing the reports. This attitude can be rapidly communicated to the rest of the group.

How To Supervise

(*Continued From Page 92*)

It may take some time for the group to regain its momentum, but before long the members will probably agree that their responsibility to the public is to act professionally and treat visitors and volunteers graciously.

Once the group appears to know the kinds of responsibilities under discussion, the leader is ready to introduce the buzz session technic suggested earlier. The training group will now be divided into three smaller groups. Each group should be asked: "What are our responsibilities to ————." Then each group should be assigned *one* of the following: (1) administration, (2) subordinates, (3) other supervisors.

After the time agreed on, the buzz groups should join around the conference table and each give its report. In several years of observing these groups, I have found that certain items are fairly predictable. The ones that will be suggested oftenest by the buzz groups are:

Group 1 — Administration

Care of patients — As administration has delegated this responsibility to them, they are in turn responsible to the administration to see that it is accomplished.

Care of property — This is the linen, drugs, beds — all the property, supplies and equipment entrusted to them to perform their jobs.

Economy — Make the best use of the supplies, equipment and personnel in their charge. Particular point is usually made of waste or stockpiling of medications.

Loyalty — Although differences of opinion can exist, the supervisors should not undermine hospital policy as expressed through the administrator.

Understand policy — It is best when policies are stated in writing. Then it is the responsibility of the supervisor to read and try to understand the policy. However, even when it is unwritten, the supervisor should endeavor to understand policy.

Know your job — The supervisor's primary responsibility is to get the job done through the efforts of others. He should know this, but must also know the department he supervises. For example, a nurse supervisor need not be the best bedside nurse in the hospital, but she should know what is expected of a bedside nurse.

Cooperation — Each supervisor has the individual responsibility to cooperate with the administration under all circumstances.

This list may appear to have been drawn up by a hospital administrator. Actually, it is a composite of the items mentioned by supervisors. Many an administrator probably thinks that his superviors would never come up with this kind of list. How does he know? When was the last time he asked them to think of their responsibilities to administration? When was the time he was prepared to listen to what they said without replying with justifications or rationalizations?

Group 2 — Responsibilities to Subordinates

Leadership — This can be accepted without too much discussion at this time, for an entire session will be devoted to it later.

Understanding of duties — This does not mean being able to do the job better than the subordinate, but at least being sensitive to the job he is trying to do.

Cooperation — The supervisor has a responsibility for recognizing that all employed by the hospital share a common goal.

Set good example — Supervisors must not only talk good human relations but actually practice this concept. Picture the supervisor who forbids his subordinates to receive personal calls on the ward. What kind of example does he set when they see him writing down a shopping list his wife is giving him over the phone!

Explain policy — There may be a limit on the number of people who can be off on weekends, but has anybody bothered to explain this to the subordinates?

No partiality — Covering the 4 to 11 shift can be quite a problem. If this is done by rotation, all should share in the rotation.

Intelligent assignment — A medical technologist should not be assigned to clean instruments for the operating room.

Training — People need to grow and it is the responsibility of the supervisor to provide this opportunity.

Is it significant that the list of the responsibilities to their subordinates is longer than lists for responsibilities to other groups? I am sure that some obvious explanations present themselves, but would they stand the scrutiny of expert investigation? Suffice it to say that the supervisors in the training group might still be viewing themselves as subordinates rather than supervisors.

Group 3 — Responsibilities to Other Supervisors

Cooperation — In a hospital, with its team concept, this may appear obvious. However, does your nursing service advise the admitting office when to expect a patient to leave?

Communication — This is another one of those areas which is so significant that an entire session will be devoted to it.

Share responsibilities — Patient care is not accomplished by any one department. ■

Above: Carpeting and paintings give unusual appearance to hall in Genesee Hospital. Cover shows another view of hall.

— And carpets in the corridors

Raymond P. Sloan

Above: The lounge area of typical bed-living room with attractive decor adds to visitors' comfort and patient's morale. Carpet separates it from patient area.

IT IS said often and truthfully that an institution, whether dedicated to health and medical care or to strictly commercial pursuits, reflects the character of its administration. No better example of this fact can be found than Genesee Hospital, Rochester, N. Y., where Lawrence J. Bradley, director, and a sympathetic board of trustees have dedicated themselves to creating a hospital atmosphere as far removed as possible from the traditional approach.

This attitude, while in line with the present trend to place greater emphasis upon the emotional needs of the patient, goes even further. It characterizes leadership that acknowledges the obligation to pioneer, to set new patterns for others to follow.

The idea of developing a completely different concept of interior styling for hospitals originated some eight years ago, not in Genesee itself, but in

INTERIOR DESIGN HAS GONE A LONG WAY FROM THE "HOSPITAL LOOK"

the nurses' home, adjacent to the hospital. The old Victorian building obviously had its day, and although structurally as good as ever, it was in dire need of face-lifting, a fact evidenced by the attitude of prospective students who came, looked and departed – before registering. Victorian atmosphere did not coincide with the younger generation's interpretation of modern living. And Genesee, like every other hospital, needed nurses.

There was but one answer, and Mr. Bradley lost no time in finding it – someone who could provide the necessary "lift." The answer, in this particular case, turned out to be Colin Campbell McLean of Chicago, who, some years previously, feeling sorry for hospital patients, to say nothing of hospital employes, had himself become a pioneer in providing hospitals with a new look.

The lounge of the nurses' residence was the initial experiment. When it became apparent what could be accomplished through proper use of color and styling technics – soft greens in this instance, with touches of warm rose for contrast, as a background for comfortable chairs and lounges arranged in congenial groupings – everyone became excited, including prospective aspirants to the nursing profession. They came, and this time they remained to register.

The success of this first venture in interior styling, coinciding with plans to add four additional patient floors to the hospital building, inspired the board members to go further. Precisely how much further they would go they could not foresee at that particular time, although the presence of pioneering spirit was already manifest by the fact that these floors were designed to provide single rooms, chiefly, the objective being to offer "more privacy for more people." A year ago the demand for such accommodations increased to the point that two similar floors were added.

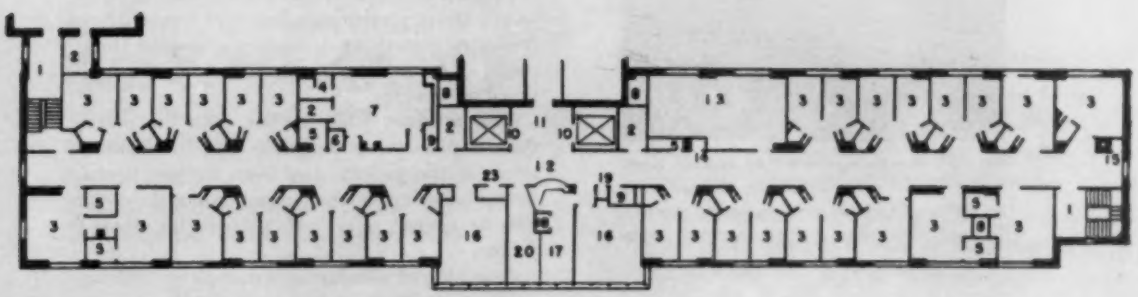
Last spring, which marked the opening of these new floors, will long be remembered in Genesee's history. The consensus of those attending was that this new concept of hospital care and surroundings would mark a milestone even in national hospital history. But about that, only time can tell.

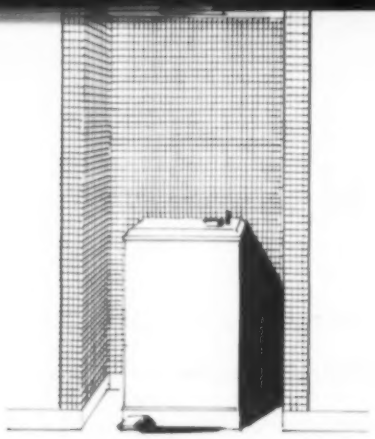
The floor plan and sketches, with accompanying illustrations, provide a general idea of the layout. Each corridor is approximately 250 feet long and 8 feet wide, not including the rooms' offsets. These single rooms, 128 in all, with the exception of a few larger bed-living rooms, are grouped in two's, set in jogs or offsets. The jogs are painted in carefully selected colors – yellow, turquoise and orange, in contrast to the more neutral main corridor walls in shades of gray or pale yellow. End walls on the sixth floor are treated with a decorative wallpaper.

What the floor plans fail to convey is the impression of quiet luxury the visitor experiences as he steps off the elevator on the sixth floor upon soft, resilient carpet. Nor does this sensa-

Key to floor plan:

1. Stairs
2. Storage
3. Bedroom
4. Lavatory
5. Bath
6. Closet
7. Utility room
8. Duct shaft
9. Janitor's closet
10. Elevator
11. Elevator lobby
12. Corridor
13. Kitchen
14. Paper chute
15. Laundry chute
16. Solarium
17. Nurses' station
18. Dumb-waiter
19. Telephone booth
20. Laboratory
21. Toilet
22. Wardrobe
23. Medicine closet





Left: Mosaic tiled drinking fountain in the corridor combines utilitarian and decorative function. Wrap-around design protects walls. Below: Modern, attractive appearance of solarium encourages ambulatory patients, gives them added incentive to walk.

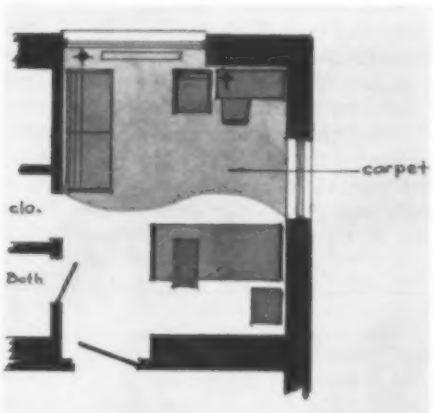
tion of cushiony comfort cease as he proceeds down the corridor. It accompanies him all the way, causing him to wonder if he is in the right place.

Frankly, the use of carpet on a patient floor is an experiment. Having received acceptance as a completely practical and desirable covering for public rooms in the hospital, it has yet to prove its adaptability to professional areas. Mr. Bradley and his associates are thoroughly aware of this fact. For this reason its use has been restricted to the sixth floor. They are convinced, however, that it is worth a trial. Final conclusions must await months of careful watching, with particular emphasis upon any possibility of infection that might arise.

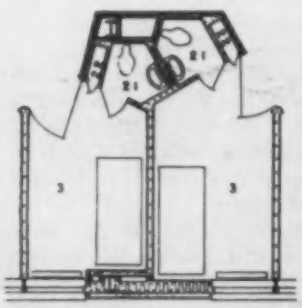
As of today the record is clear, and everyone is enthusiastic – patients, doctors, nursing staff, porters, maids, to say nothing of the public. Mr. Bradley's staff reports it is not unusual to receive requests from doctors to allo-

(*Continued on Page* 160)

Below: Drawing shows how sculptured carpet form is used to separate visitor area.



Floor plan on the opposite page and detail drawing (below) of one of the bedrooms gives general idea of layout. Bedrooms are grouped in two's. Key to both plans is on opposite page.



Don't Underestimate the Value of Salesmen

Supply salesmen are a valuable, but often overlooked, source of information to administrators not only about new products and technics of purchasing but also about the way hospitals are operated and what the public thinks of them

James G. Carr Jr.

SUCCESSFUL management of any endeavor requires the use of every resource. Yet, many administrators fail to use to full advantage one resource which is available almost daily in our hospitals—the various salesmen who visit our institutions—the drug and hospital supply men, the food merchants, the equipment and machinery specialists and the many other persons who offer their wares and services to us.

Salesmen seem to be the forgotten members of the hospital team. Hospital administrators are constantly urged to consider and correlate their board members, physicians, employes and volunteers in team effort, but no one ever seems to mention the salesman as an important member of the team. His contribution to the hospital success story, however, is impressive and his unrecognized and unused potential is worth serious consideration.

In the opinion of some administrators and purchasing agents the salesman is an intruder on their time who is to be dismissed at the earliest possible moment. During the salesman's visit, their minds wander to other duties which they consider far more important than the business at hand. They forget, or perhaps never stop to consider, that the salesman frequently is a skilled specialist whose advice is worth seeking. Labeling the salesman an intruder is not only unsound, but it may result in costly purchasing mistakes which could have been avoided easily by a little more attention to the salesman.

Of course, the team idea does not imply that each salesman's visit should be extended into a lengthy, detailed session. It is just as unwise to keep the salesman beyond a reasonable time, as it is to hurry him through his presentation. The administrator or purchasing agent should control the length of a sales interview; keeping in mind that the salesman is entitled to reasonable time to present his story but remembering that time is also important to the salesman and should not be wasted on trivial matters. Care must be taken to avoid indicating unrealistic interest. No salesman wants to make a detailed presentation of a product where no purchase is anticipated.

To the new person in the hospital field, the salesman can make a significant contribution. One of the big problems confronting the novice is learning hospital terminology. In some instances, the purchaser may not know what he is buying because he is unfamiliar with the technical terminology; rather than admit his ignorance, he boldly proceeds to initiate purchases that a conscientious salesman could prevent and thus save embarrassment which might adversely affect both purchaser and salesman.

Becoming acquainted with the multitude of hospital supplies and equipment becomes more complex because of the need for keeping informed on new items and procedures. The pace of medical progress has tended to accelerate each year during the last decade and it is reasonable to assume that it will continue to do so in the years ahead, possibly at an even greater rate. Therefore, all hospital purchasers must keep informed on new products and this requires the use of all available resources. The purchaser cannot afford to neglect any source of information. The advice of a salesman is important, since it is usually the latest available word and may prevent the purchase of obsolete items.

Salesmen are not limited solely to a knowledge of their own products. They see other hospitals, they talk to many other hospital people, and frequently they have good hospital operational information. They can tell an administrator some things about his hospital that may be well worth his consideration.

No one, especially the salesman, contends that he is a hospital consultant but, in some areas, he could probably teach the consultant a thing or two. He knows what kind of a recep-

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tion a stranger receives as he enters the hospital; he knows whether the housekeeping is as good as or better than that of the other hospitals he visits; he frequently hears comments from employes or visitors or from someone in the hotel he stayed in the night before, comments that may be more informative than a basket full of public opinion polls. In a sense, he is the public about which we are always concerned. Even more, he represents a well informed segment of that public and his opinion is valuable.

At meeting after meeting, we hear the cry, "Give the patient a pleasant reception." The salesman is frequently

(*Continued on Page* 156)

SALESMEN HAVE NO BUSINESS TO TRY TO "BUY" BUSINESS

THE relationship between the hospital and the salesman is not a one-sided affair. The salesman has obligations and responsibilities, too, and he must establish confidence in both his firm and himself, before he can expect to be accepted as a member of the hospital team. We have indicated how administrators and purchasing agents might improve their attitude toward salesmen. What, then, are some of the complaints registered by administrators and purchasing agents about salesmen?

Salesmen frequently impose unreasonably on the time of administrators and purchasing agents. Often, salesmen insist on presenting detailed sales data on items in which the hospital has no current interest, and some of them waste valuable time relating the latest gossip concerning other hospitals on their circuit. A certain amount of small talk is usually conducive to creating a friendly and informal atmosphere, but scandal and gossip are likely to be offensive and may well produce a psychological resistance on the part of the prospective buyer.

Salesmen should be particularly careful to avoid over-selling. Claims for their products that exceed the facts and persuasion to buy quantities far beyond needs should assure little or no future business from the institution involved. I know of one instance where a fast talking salesman sold almost a 50 year supply of an item to a hospital. The immediate sale may have been considered a success, but he had better remember it for a long time, since it was quite possibly his last sale to that institution.

Salesmen must avoid indications of resentment; their ability to accept the loss of a sale gracefully is important in the maintenance of good relations with the purchaser. Also, criticism of competitors should be avoided carefully at all times. Salesmen who are disgruntled because they do not receive sizable orders during each hospital visit, and who infer that "the hospital owes me a certain portion of its business just because I call here," need to evaluate their sales technic because their attitude indicates a serious lack of sales maturity.

The most delicate area in the salesman-purchaser relationship involves what might be termed the personal area. Just how friendly should the salesman and the purchaser become? Friendship sometimes leads to obligations and these obligations may in turn influence or even negate the possibility of unbiased purchasing. Administrators, purchasing agents, and salesmen should be particularly careful to maintain a strict separation between their business and their social obligations.

Closely related to the question of friendship is the problem of gift giving. Administrators and purchasing agents who accept valuable gifts from salesmen are a discredit to the hospital field; salesmen who present valuable gifts to hospital personnel are in the same category. Administrators should develop definite policies concerning the receipt of gifts by both their employes and themselves. The policy should be designed to eliminate any possibility of influencing purchases as a result of gifts. In our hospital, department heads are instructed to inform the administrator of the receipt of gifts or similar offers. Only gifts of small monetary value are exempt from this ruling. By the term "small monetary value" we mean such items as an inexpensive ballpoint pen, a small box of candy, a carton of cigarets, a luncheon or dinner. In many instances refusal to accept such small value gifts would be more discourteous than wise, but even in this area of what might be termed "normal social exchange," administrators and purchasing agents should consider the source and the circumstances, avoid any tendency to impose or accept favors too frequently, and consider picking up a luncheon or dinner tab themselves in order to reciprocate properly.

In instances where gifts are received in our hospital which have any significant value, they are either retained by the hospital instead of the individual or returned to the giver. For example, an expensive assortment of cheeses, jams, and other food delicacies, given to our dietitian, was placed on the employes food line in our cafeteria and given to all employes by this method. Regardless of what is done with the expensive gift, the giver is politely informed that he should send no more presents, if he wishes to continue doing business with this hospital.

There are some administrators and purchasing agents who feel that the receipt of gifts is a fringe benefit of their job. One purchasing agent told me recently that he could hardly wait until Christmas when he looked forward to receiving all kinds of gifts; my comment to him was that any administrator or purchasing agent who openly encourages or requests gifts of any kind from salesmen should be discharged. Salesmen should proceed with caution when dealing with a purchaser who does business on the basis of receiving gifts or other favors; likewise, administrators and purchasing agents should beware of the salesman who attempts to buy business through the presentation of gifts. In both instances the principles of sound purchasing are being badly abused. ■

ABOUT PEOPLE

Administrators


Esther Klingman

Gerald L. Aldridge has been appointed administrator of Theda Clark Memorial Hospital, Neenah, Wis., succeeding **Esther Klingman,** who has retired after 18 years in the post. Mr. Aldridge had been administrator of Mary Lanning Memorial Hospital, Hastings, Neb., since 1951. He has a bachelor's degree from the University of Denver and a master's degree in hospital administration from Washington University, St. Louis. He is a member of the American College of Hospital Administrators, past president of the Nebraska Hospital Association, and a member of its executive committee, past chairman of the Council on Nebraska Blue Cross, and a trustee of the Midwest Hospital Association. **James Kenney** has been named administrator at Mary Lanning. Miss Klingman is a former president of the Wisconsin Hospital Association and has been active in the affairs of the Tri-State Hospital Assembly. She is a fellow of the American College of Hospital Administrators.

Mrs. Marguerite Yeide has resigned as administrator of Gnaden Huetten Memorial Hospital, Lehighton, Pa. She had served as head dietitian before becoming administrator in 1953. Mrs. Yeide is secretary-treasurer of the Eastern Regional Hospital Association of Pennsylvania, and is a member of the advisory council of Capitol Blue Cross and the Pennsylvania Hospital Association.

Charles E. Hall has been appointed administrator of West Plains Memorial Hospital, West Plains, Mo., replacing **Carden Astin,** who resigned. For the last six years Mr. Hall has operated the Physicians Laboratory, Jefferson City, Mo.

Dr. Donald C. Richards, emeritus chief of obstetrics, has been named acting administrator of Easton Hospital, Easton, Pa., replacing the late **Arthur H. Brittingham.** Dr. Richards was chief of obstetrics from 1934 to 1955 when he became emeritus chief. He is past president of the hospital medical staff, and past president of the Northampton County Medical Society. He is a diplomate of the American Board of Obstetrics and Gynecology, and a founding member of the American College of Obstetrics and Gynecology.

J. L. Henry has resigned as administrator of Park View Hospital, El Reno, Okla., to accept a position as assistant administrator of Baptist Memorial Hospital, Oklahoma City, which is scheduled for completion in February.

Sister M. Alban, former administrator of Santa Rosa Hospital, San Antonio, Tex has been appointed administrator of St. Joseph's Hospital, Fort Worth, Tex. She has been succeeded at Santa Rosa by **Sister Mary Vincent,** former administrator of St. Joseph's.

Dr. Horace Smith, formerly manager of Veterans Hospital, Omaha, has been appointed manager of Veterans Hospital, Pittsburgh. He has been succeeded at Omaha by **Dr. Blanton E. Russell,** formerly manager of Veterans Hospital, Cincinnati.

Sister Mary Louis, formerly director of nursing at Creighton Memorial St. Joseph's Hospital, Omaha, has been named administrator of Good Samaritan Hospital, Kearney, Neb., succeeding **Sister Mary Getulia. Sister M. Marth Hund,** formerly director of nursing at St. Elizabeth Hospital, Lincoln, Neb., has been appointed director of nursing at Creighton Memorial St. Joseph's.

Robert G. Curran and **Richard G. Warner** have been named assistant administrators at Boston City Hospital, Boston. Mr. Curran was formerly assistant administrator of Johns Hopkins Hospital, Baltimore, and Mr. Warner until recently was administrative assistant and former assistant managing director of New Britain General Hospital, New Britain, Conn.

G. K. Palin has been appointed administrator of Lachine General Hospital, Lachine, Que. He had been administrator of Alexandra Hospital, Montreal, Que., since 1951. He is a member of the American College of Hospital Administrators.

Leonard E. Watson has been appointed administrator of Deaf Smith County Hospital, Hereford, Tex., succeeding **T. E. Seigler,** whose resignation was announced in The MODERN HOSPITAL last month. Mr. Watson was formerly assistant administrator of Highland General Hospital, Pampa, Tex.

Mary E. Donahue, R.N., has been named administrative assistant at Malden Hospital, Malden, Mass., where she has been educational director at the school of nursing for the past four years.

Sister M. Alphonsia, formerly at St. Francis Hospital, Colorado Springs, Colo., has been named assistant to the administrator at St. Mary's Hospital, Columbus, Neb.

George A. Lerrigo, administrator of Randolph County Hospital, Roanoke, Ala., has been appointed administrator of North Adams Hospital, North Adams, Mass.

Mother Mary Olivia has been named administrator of Tawas Hospital, Tawas, Mich., replacing **Sister Rita Louise.** Also announced was the appointment of **Sister Barbara Marie** as director of nursing, succeeding **Sister Rose Anthony,** who will join the staff of Mercy Hospital, Monroe, Mich.

Sister M. Pacifica, former superior at St. Joseph's Hospital, Omaha, has been named superior and administrator at St. Mary's Hospital, Emporia, Kan. **Sister M. Justa** will succeed her at St. Joseph's.

Richard W. Hunsaker has been appointed assistant administrator of Brockton Hospital, Brockton, Mass. He had been assistant at Children's Hospital, Columbus, Ohio. He has a bachelor's degree in business and public administration and a master's degree in hospital administration from the University of Minnesota.


Frank F. Morin

Frank F. Morin has been appointed administrative assistant at Peninsula Hospital, Burlingame, Calif. Mr. Morin received his bachelor's degree from Stanford University and his master's degree in hospital administration from the University of California. He was formerly administrative resident at the hospital.

Robert E. Dornfeld has been appointed administrative assistant, Norwood Hospital, Norwood, Mass. He

(*Continued on Page* 194)

Art Is Good Medicine for Disabled Patients

PICTURED on this and the next two pages are examples of the works of art created by patients at Veterans Administration Hospital, Hines, Ill., under the guidance of the occupational therapist. In the photograph below, Reynold Gobrewski, a patient suffering from muscular dystrophy, is shown painting "Variations on a Theme" with the brush held in his teeth. Mr. Gobrewski's first work of art was a numbered oil painting, followed by copy work from magazine reproductions. The occupational therapist encouraged him to do original work and the scope of his painting at present extends from abstractions to realism in landscapes and still life. At the right is the finished painting of "Variations"; above is "The Clown."

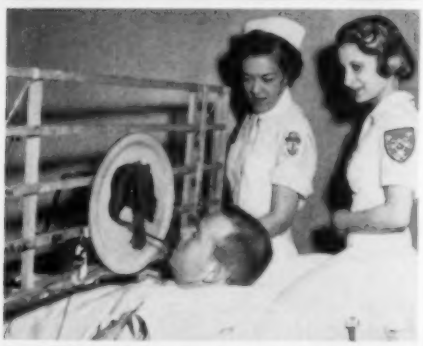


Exhibit Shows the Value of

Left, top: Painting with brush held in teeth is preparation for writing activities. This patient has improved and is now receiving treatment in the manual arts training section. Center: Confined to a Stryker frame, patient paints large wooden plate from a supine position. Painting has provided means of creative self-expression for this severely disabled veteran. Bottom: Suspended arm supports enable the patient to do copper tooling. The patient in this case is Crayton Mann, who was formerly administrator of Welborn Memorial Baptist Hospital, Evansville, Ind. Mr. Mann was injured some time ago in a diving accident. Creative therapy helps prepare patients for activities of daily living by improving their coordination and strength. It helps them adjust to the social and vocational limitations they face.

Above, left: Center display board at exhibition shows paintings done by patients in the paraplegia and neurological clinics. Right: Showcase and pegboard display crafts, jewelry, ceramics and art work from the psychiatric occupational therapy clinic. Opposite, left: Work done by neurological patients is exhibited on easels. Right: Paintings done by two quadriplegia patients, both of whom hold the brushes between their teeth in order to paint.
Emphasis in the whole exhibition was on the occupational therapy value as treatment and rehabilitation rather than on the finished work as art.

Occupational Therapy in Rehabilitating Patients

L. H. Gunter

ONE of the simplest and most effective methods of stimulating public interest in rehabilitation was recently undertaken at the Veterans Administration Hospital, Hines, Ill. An exhibition of patient activities in the occupational therapy section of the Physical Medicine and Rehabilitation Service was planned for this specific purpose.

A three-day exhibition, "Art in Occupational Therapy," was held in the nurses' recreation lounge and in spite of inclement weather, more than 200 visitors attended the exhibit. Some of the entries are shown below.

Mr. Gunter is assistant manager, Veterans Administration Hospital, Hines, Ill.

Publicity releases prior to the exhibition featured the accomplishments of several severely disabled veterans. These releases were brief and factual, giving the name of the patient, his disability, the rehabilitation objectives, and the occupational therapy technics employed. Pictures showing the patient at work in occupational therapy were included. Attempts to interpret occupational therapy as a specific treatment medium in physical medicine and rehabilitation, rather than as "arts and crafts," were considered successful largely owing to the careful planning of the publicity releases and the captions which stressed the treatment objective rather than the finished article.

Right: Assistant chief of the occupational therapy section shows model ship to chief of physical medicine and rehabilitation services and a guest. Case displays crafts made in tuberculosis division's graded therapy activities.

Two basic forms are the secret of a combined admitting and accounting system that reduces the making and keeping of records to the minimum

Admissions and accounting system eliminates late and lost charges

Sister Mary Gertrude

A FEW years ago Bon Secours Hospital, Grosse Pointe, Mich., instituted a system for admission and accounting that is so simple, so streamlined and all-inclusive that no basic changes have been made since. Each department has all the written information required when it is needed. Most important, writing time for all personnel has been reduced to a minimum.

It starts in the admissions office with a six-part unit set of carbon interleaved forms. Here all the essential information about the patient is typed just once. All time consuming, unimportant data have been eliminated. Now, because it takes only a few minutes to fill out the form, admissions are speeded up and patients are kept at ease during a time when tensions are the highest.

Let us follow these six color-keyed parts of the set:

Part A-1 is the patient's chart. This goes to the desk on the floor to which the patient is assigned (white).

Part A-2 is the patient's ledger and is forwarded to the accounting office (buff ledger stock).

Part A-3 goes to the telephone operator for use in the telephone selector file (goldenrod).

Part A-4 becomes the record room copy (pink).

Part A-5 is the chaplain's copy (green).

Part A-6 goes to the office for the attending physician (white).

The second phase of the system concerns charges made to the patient's account during his stay at the hospital. Each service department uses a unit ticket recorder. This consists of individual charge tickets and a running tally sheet, both attached to a recorder similar to a portable clip board. Unit charge slips are in pad form (consecutively numbered) and slide up and down on a track under the tally or summary sheet. One writing fills in both the charge slip and the entry on the tally. Each department has its own identifying color for easy sorting in the accounting office.

The tally sheet is forwarded to the accounting department at the end of each shift and used to reconcile the charge tickets. This tally provides a check against lost charges.

In the accounting office, upon receipt of the ledger copy of the admission form (A-2), a two-part statement is headed up in a typewriter from the information on the ledger sheet. The ledger is inserted in the statement form and filed alphabetically. Now the account is ready to receive posting entries as charge slips are received from the various service departments.

As accumulated, unit charge slips are sorted alphabetically ready for posting to the ledgers. (All charges are normally posted once a day.) These ledgers are kept up to date ready for the cashier as patients are discharged. If there are any sorted but unposted charge slips, these can be added to the ledger and statement in a matter of a minute.

Two additional features increase the convenience and effectiveness of this system:

Perforated stubs on the left side of parts A-3, A-4 and A-5 are removed after the admission form is filled out and are attached to the patient's chart (A-1). These stubs are later returned to the designated departments by the floor as a signal that the patient has been discharged.

Outpatient charges are handled with the same unit slip recorders. Here both the tally sheets and the charge slips are keyed as "O-P" charges for the accounting office or cashier. If outpatient services are to be paid for in cash, charge slips go directly to the cashier.

Two supplemental forms are used at Bon Secours with this system:

In maternity cases a separate five-part record of admission form is filled out for the newborn child. This form is the same as the six-part but does not contain the (A-2) ledger card because charges accrue to the mother's statement. Routing of the other parts is the same.

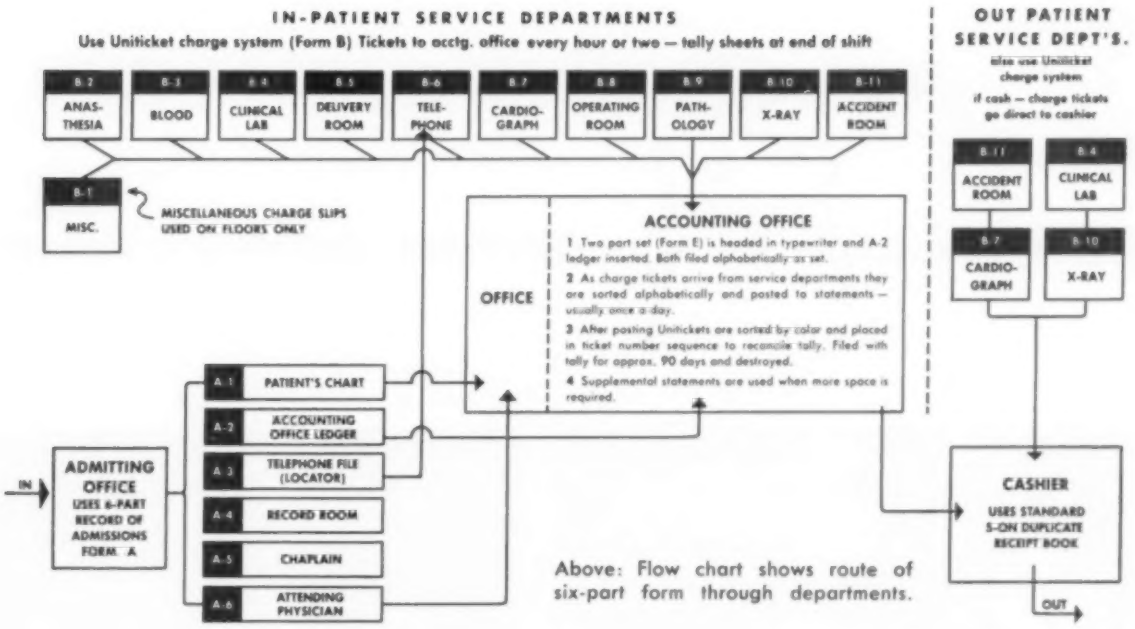
Supplemental two-part statement forms and ledger cards are used as carryover copies if additional posting space is required. Only the patient's name and page number need be typed in at the top.

When the patient is discharged and the account settled, the cashier makes out a receipt using a standard 5-on duplicate style receipt book. The patient receives a copy of the complete statement along with the original copy of the receipt. The accounting office retains the second copy of the statement and the ledger card.

This streamlined system offers many advantages. Here are a few of the more important:

Lost charges have been virtually eliminated. After posting, unit charge slips are cross-checked against the unit

The author is superintendent, Bon Secours Hospital, Grosse Pointe, Mich.



Above: Flow chart shows route of six-part form through departments.

slip recorder tally sheets which are turned in at the end of each shift. This is possible because both carry corresponding consecutive numbers.

Supplemental billing after patient discharge has been eliminated. Because service charge slips are received promptly and posted daily, patient's account is always ready for discharge and payment. Any unposted charge slips can be added to the ledger in a matter of a minute.

Writing operations have been cut to a minimum, yet every part of the patient's record is immediately available where it is needed and to the people who need it.

Errors are cut to a bare minimum because no copying of information is required.

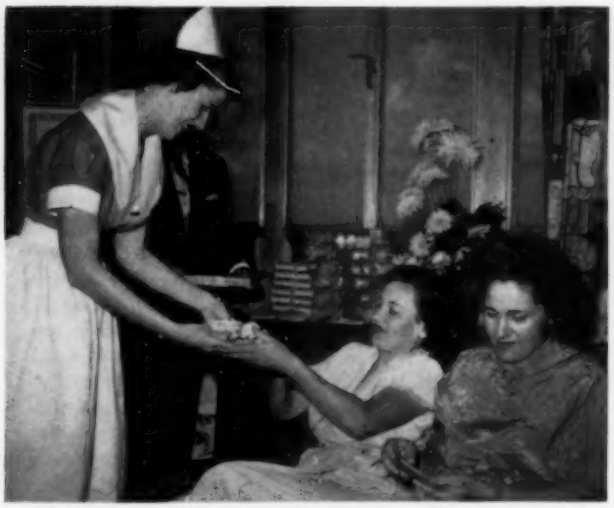
A minimum of equipment is needed. Bon Secours uses a standard make typewriter in the admission office and is assured of good legibility on all parts of the form set because of the extremely lightweight carbon paper, and because each form contains new carbons. An automatic machine speeds the posting operation in the accounting office. Inexpensive unit recorders are provided each of the 11 service departments.

For the hospital administrator, the most important aspects of this system are the elimination of late or lost charges and the time it saves. Key employes have more time for the really essential job at hand — that of giving the best service to the patient. ■

Left: Unit ticket recorder form. Every service department has its own charge slips which are identified by color. Making charge entry on tally sheet automatically prepares charge slips for accounting.

Coffee parties help

Quinton Sherrer



New mothers take part in Coffees, too, if they have not attended one previously. Here, one gets coffee from a student nurse and the other registers for a door prize drawing.

Movies on child care are shown expectant mothers at Baptist Memorial's Coffee party. Each receives free literature that illustrates the films they have seen.

THE first Wednesday of each month Memorial Hospital (Baptist) in Houston is a-buzz with expectant mothers and prospective fathers who have been invited to the monthly "Maternity Coffee."

The Coffee is appropriately held on the obstetrical floor – in the fathers' waiting room. Its purpose: to take away unfounded fears about childbirth.

The parents-to-be are served refreshments and are shown films on baby care and formula making technic. A short talk is made by the obstetrical supervisor or one of the doctors and questions are encouraged. The highlight of the event is a tour of the private labor rooms, the delivery rooms, and the recovery rooms. Memorial is the only hospital in the Houston area which has a recovery room for maternity patients only.

If the attendance is large, the group is divided into several tours—each with an obstetrical nurse on hand to explain what will happen in each room. Again, questions are encouraged and answered in layman's language.

A tour to the newborn nursery and a peek into a postpartum room concludes the tour. There are usually between 25 and 35 present.

The Coffee is sponsored jointly by the nursing staff and the volunteer workers together with the owner of a local diaper service and a medical service representative of a national milk company.

Physicians, nurses and the prospective patients are enthusiastic about the Coffee. It is the only known project of its kind in Houston.

The doctors send the hospital volunteers a list of their expectant mothers and the volunteers send a printed invitation from the hospital. The mothers-to-be do not necessarily plan to come to Memorial to have their babies. Any prospective mother in the Houston area is invited, and fathers

Mr. Sherrer is public relations director, Memorial Hospital of Houston.

to ease mothers' fears of childbirth

Expectant mothers tour the delivery rooms at the monthly Maternity Coffee hours, which were started in October 1955 by Marie Wroe, obstetrical supervisor. Guests receive gift packages of various sorts from commercial companies that take part.

Below: A trip to the newborn nursery and a look into the postpartum room concludes the tour by the expectant mothers. Coffee is sponsored jointly by the nursing staff and volunteers, plus the owner of a local diaper service and the medical service representative from a national milk company.

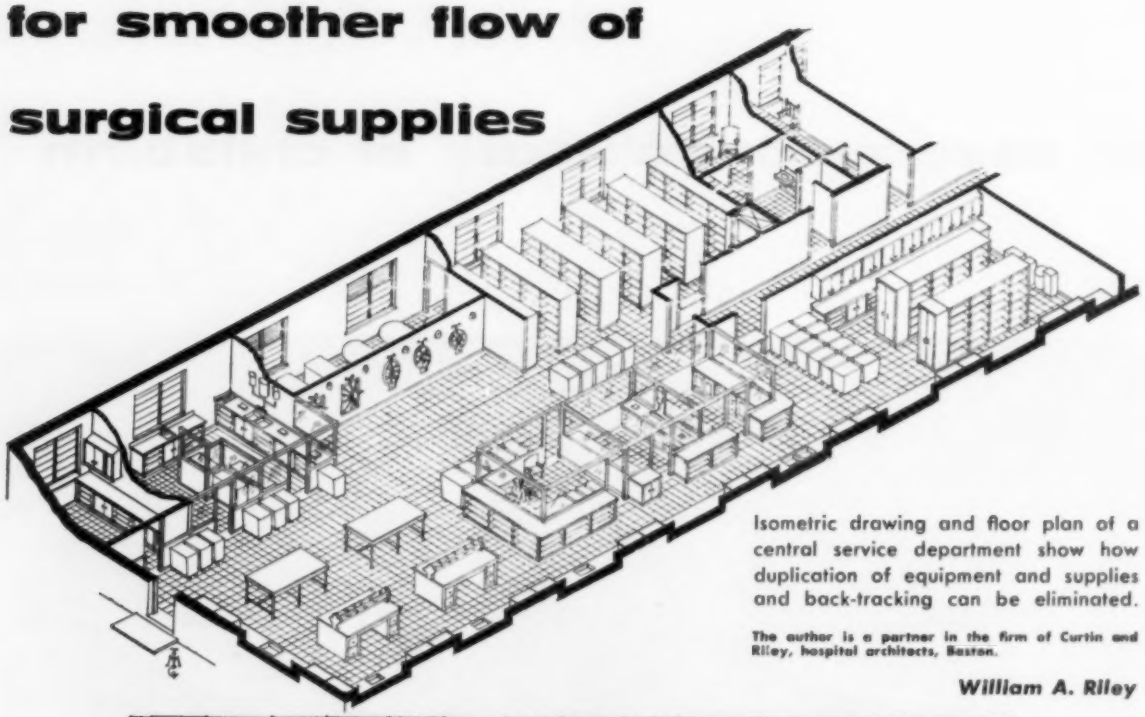
are especially welcome. Often after the Maternity Coffee, however, they tell their doctors they prefer Memorial Hospital.

Said one mother, "I have an older child. I wish I could have attended something like this then. I was so frightened."

Some new mothers still confined to the hospital request that they be taken by wheelchair to the Coffee. These are usually the ones who had never attended a Coffee and wanted to see "where I have been." The movies prove helpful to them also.

Does the Maternity Coffee help make better patients? The doctors and nurses agree that it does. ■

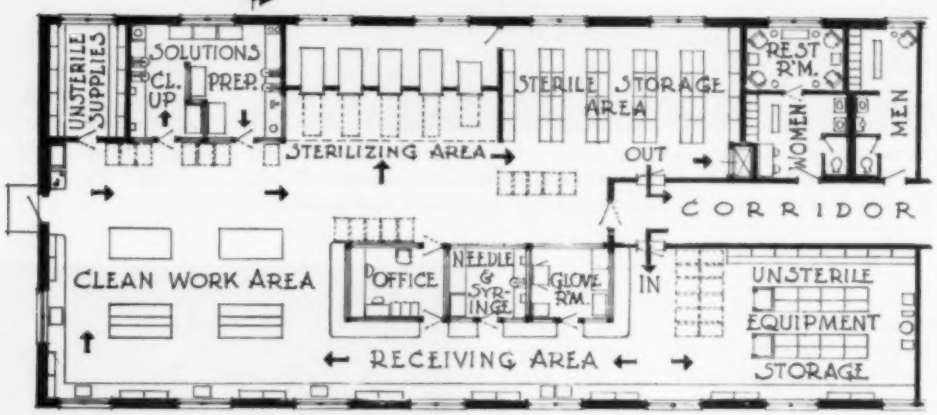
Centralize central service for smoother flow of surgical supplies



Isometric drawing and floor plan of a central service department show how duplication of equipment and supplies and back-tracking can be eliminated.

The author is a partner in the firm of Curtin and Riley, hospital architects, Boston.

William A. Riley



THE "central service unit" for a 500 bed general hospital shown here is designed for increased productivity, better utilization of personnel, more economical operation, decreased lapse of time between need and availability, and better understanding of responsibilities – all of them leading to better patient care.

The traffic flow indicates the complete visual control by the unit supervisor, elimination of equipment duplication, absence of back-tracking, and the resulting smooth flow of service from receiving to dispensing.

Central service should imply an adaptation to the use of modern industrial production methods, such as availability of supplies, an uninterrupted production flow, and quick delivery of product wherever needed.

Central service used to be in the surgical department. It has grown too complex to be included there.

The notable strides of medical science, and the shorter stay of patients, have added many patients with increased demands in volume and variety for professional supplies.

Consider what the introduction of antibiotics, increased use of parenteral fluids, growth of blood banks, and the use of intravenous anesthesia have meant to the hospital inventory of syringes and needles alone, and the same holds true for all other items.

Work simplification offsets to some extent the shortage of trained personnel, and the relation of central service to certain hospital areas is a major part of this simplification.

The surgical department should be on ground floor to avoid break in vertical transportation in time of need.

Central service is best served by elevator from the laundry, hospital storage, and general storage below, with service to pharmacy, laboratories and surgical department on same floor, and by dumb-waiter up to delivery floor above. ■

Preparation time: 14 hours

Tracer light demonstrates work, time and space required by premises-made soups.

Preparing 5 gallons of vegetable beef soup took 2 hours' labor, 12 hours' cooking time, used up valuable counter, stove and refrigerator space. (Movement of light out of photo shows frequent trips to storeroom and cold locker.)

Save man-hours, please patrons

Campbell's time: 15 minutes

Preparation takes little counter and stove space – one burner is used for only a few minutes.

Small batch can be made up quickly. No refrigerator space required. The soup you serve contains all the ingredients of the premises-made soup shown above, yet all you do is open can, pour into kettle, add water and heat.

with Campbell's quality Soups

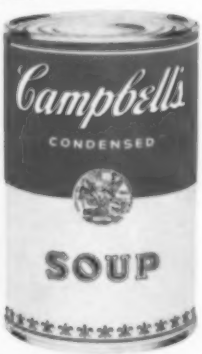
Scientific studies in commercial kitchens show that Campbell's Soups mean substantial savings in ingredients – and in time, space and man-hours you can profitably employ for other purposes. Yet there's no compromise with quality when you serve Campbell's Soups. For Campbell's uses the finest ingredients and prepares them with the same professional care that you insist on in your own kitchen.

And when you consider the number of different Campbell's Soups – all with proven taste appeal – you'll see the opportunity for menu variety that increases soup sales. Especially when you personalize your soups with your own seasonings and garnishes.

Campbell Soup Company

Restaurant Division, Camden 1, N. J.

Idea: Create your own soup from two Campbell's Soups. Try Purée Mongol–1 can Cream of Tomato, one can Green Pea–season to taste for a dramatic, exciting menu sensation that sets up appetites.



CHOOSE FROM EIGHTEEN 50-OUNCE SOUPS

What Hospitals Don't Do About Public Health

Results of a questionnaire survey indicate that hospitals need to do a better job of establishing sound public health programs for the welfare of their patients and employes

John J. Hayes

AS A social institution, the hospital has the direct responsibility of caring for the sick and injured; however, it is also responsible for establishing a sound preventive medicine program within the hospital which elevates the quality of patient care, in addition to safeguarding the health and well-being of the employes.

Because it was felt that, collectively, hospitals were deficient in the sound public health practices, we developed and forwarded a questionnaire to the commissioners of health of the several states. The questionnaire was designed to determine the answers to two questions:

1. What is the relationship of state licensure laws to hospital approval by the Joint Commission on Accreditation of Hospitals?
2. Is there a pattern of deficiencies common to hospitals?

The term "public health deficiencies" used in this presentation will be considered as those practices or existing conditions within the hospital that would impair patient recovery, or place in jeopardy the health of hospital employes.

Question 1. Does your state have a hospital licensure law?

Of the 38 states responding to the questionnaire, only three—New York, Louisiana, and Texas—have failed to legislate a state hospital licensure law.

Hospital licensure laws in the several states have different applications. For example, Pennsylvania has a licensure law, but it only applies to proprietary hospitals. Florida and Wyoming also have licensure laws, but they apply only to hospitals built with, or additions to existing facilities made with, the aid of Hill-Burton financing. However, for the most part, it may be said that the tendency toward state licensure is the vogue in the United States.

Question 2. If the answer to Question 1 is "Yes," is the law written so it could be possible for hospitals to be approved by the Joint Commission on Accreditation of Hospitals, yet fail to qualify for a state license?

The states have shown, in answering this question, that they are separate entities in formulating hospital licensure laws. The answers indicate that some states feel that approval by the Joint Commission on the Accreditation of Hospitals should be a prerequisite for state licensure. On the other hand, other states have chosen not to tie their hospital licensure to hospital accreditation.

Question 3. If the answer to Question 1 is "Yes" (the state has a licensure law), what per cent of the hospitals failed to obtain a license because of public health deficiencies? Over 200 beds, ...%. Under 200 beds, ...%.

It was hoped that this question might reveal a trend indicating a need for correcting public health deficiencies. However, 25 states reported the following:

State	Over 200 Beds Per Cent	Under 200 Beds Per Cent
Arkansas	0	0
California	0	0
Colorado	0	1
Connecticut	0	0
Georgia	10*	66*
Illinois	**	**
Iowa	0	0
Kansas	0	17
Kentucky	0	33.6
Maryland	0	0
Minnesota	**	**
Missouri	**	**
Montana	0	10
New Mexico	0	0
North Carolina	0	0
Oklahoma	0	0
Oregon	0	0
Rhode Island	0	0
South Carolina	0	0
Tennessee	0	0
Utah	0	0
Vermont	0	0
Virginia	0	0
Washington	**	**
West Virginia	0	6

*Provisional approval.
**States not having completed a survey because of the newly enacted legislation.

This survey does not mean that only a few small hospitals are guilty of public health deficiencies. It reveals that the laws are not stereotyped. Some states have enacted laws that deal primarily with the safety and fire hazards of the hospital physical plant, while others place more emphasis in the areas covered by the Joint Commission survey. As this paper develops, it will be shown that problems involving public health are present in most hospitals, regardless of size or geographic location.

Question 4. What are the five most chronic public health problems you find in hospital dietary departments?

John J. Hayes is the executive coordinator of St. Mary's Infirmary, Galveston, Tex. A graduate of the University of Missouri, he received his master's degree in hospital administration from Washington University. He developed the information in this article while he was serving his administrative residency at the Veterans Administration Hospital in Houston. Prior to his work in hospital administration, Mr. Hayes spent three years in the field of public health in Missouri.

For additional information, use postcard facing Cover 3.

Under 200 beds. Over 200 beds.

A total of 146 different problems were listed in answer to this question, 93 of them found in hospitals under 200 beds and 53 found in hospitals over 200 beds.

The deficiencies in hospitals over 200 beds and under 200 beds have been grouped in the order of frequency as shown in the table at right.

Problems in the area of public health in hospitals over 200 beds, for the most part, parallel those found in the hospitals under 200 beds. However, physical plant inadequacies seem to be less of a problem in the larger institutions. The deficiencies are listed in the column at right.

It is interesting to note that a large per cent of inadequacies listed fall into areas that are correctible without any revision of present physical facilities. In some cases all that would be involved would be amending or developing an administrative procedure.

Question 5. Do you find any public health problems in hospital laundries? If "Yes," what are the five most frequently found in the order of their importance?

Usually, the hospital laundry is an integral part of most hospital operations. Laundry products are used in every department and service in the hospital. Therefore, it is important to determine if the linen, its processing, or its distribution is serving as a vehicle for the transmission of disease within the hospital.

In response to this question, 50 deficiencies were mentioned. To indicate where these deficiencies exist, they have been grouped into the categories shown at right (with percentages).

Question 6. What do you consider the five paramount public health deficiencies found in the obstetrics and nursery departments?

The marked decline in the premature and infant mortality rate over the last quarter century has been the result of a joint effort on the part of the physians, the hospitals, and public health agencies. However, there is still room for improvement. It is true that this improvement is needed most by the smaller hospitals, but there are some areas to which, in the opinion of public health people, the larger institutions could give consideration.

Answers to this question totaled 100. Many of the answers are similar, indicating that a sizable group of hospitals are having the same problems. Deficiencies have been grouped into the following principal areas and are presented with percentage of frequency in reporting. (*Cont. on p.* 115)

Question 4:

HOSPITALS UNDER 200 BEDS

General Sanitation and Housekeeping (48.38%)

1. Poor dishwashing practices
2. Lack of general cleanliness
3. Improper storage of dry food stuffs
4. Improper storage of refrigerated foods
5. Lack of insect and rodent control
6. Poor technics of food handling
7. Poor garbage storage and disposal
8. Use of bulk milk container for dispensing milk to patients
9. Open storage of dishes
10. Mold growth on walls and ceiling of walk-in refrigerators
11. Medications stored in dietary refrigerators
12. Inadequate lavatory facilities in food preparation areas

Dietary Personnel (20.43%)

1. Absence of qualified supervisory personnel
2. Employe health program lacking
3. Lack of inservice training program
4. Insufficient number of personnel
5. Safety program lacking
6. Inadequate fire protection available

Food Preparation and Serving (19.35%)

1. Insanitary food serving technics
2. Tendency to plan menus from day to day
3. Inadequate caloric content in diets
4. Lack of diet selection by the patient
5. Need for more supervision in the preparation of modified diets
6. Vegetable cleaning vats being used for poultry cleaning
7. Insanitary methods of handling ice for drinking purposes

Physical Plant Deficiencies (9.67%)

1. Poor lighting and ventilation
2. Physical layout poor
3. Lack of refrigerated storage space
4. Defective plumbing
5. Antiquated physical plant

Diet Education for Patient (2.15%)

1. Discharge diets not adequate to meet the socio-economic needs of the patient
2. Lack of patient diet instruction

HOSPITALS OVER 200 BEDS

General Sanitation and Housekeeping (43.39%)

1. Poor dishwashing practices
2. Lack of insect and rodent control program
3. Poor housekeeping
4. Poor practices for the storage and disposition of garbage
5. Lack of lavatory facilities for employes
6. No care given to cleanliness of equipment
7. Improper refrigerated storage practices
8. Improper storage of food stuffs

Dietary Personnel (16.98%)

1. No concern for personnel health
2. Unqualified supervisory personnel
3. Lack of inservice training program

Food Preparation and Serving (15.09%)

1. Poor food serving practices
2. Failure to provide minimum caloric content in diets
3. Poor practices for handling ice for drinks
4. Use of bulk milk containers for dispensing milk
5. Improper food handling technics
6. Poor food service organization

Physical Plant Inadequacies (11.32%)

1. Poor ventilation and lighting in food production areas
2. Inadequate equipment to handle the job
3. Antiquated equipment
4. Defective plumbing
5. Inadequate refrigerator space

Diet Education for Patients (13.20%)

1. Lack of organized diet education program for patients and for patients' families
2. Failure to adapt discharge diets to the socio-economic status of the patients

Question 5:

Linen Handling and Distribution (28%)

1. Insanitary collection technic for soiled and contaminated linen
2. Lack of protective measures for personnel handling contaminated linen
3. Improper handling of nursery linen

Physical Plant Deficiencies (24%)

1. Improper lighting and ventilation
2. Inadequate equipment to handle the load
3. Inadequate space within the laundry
4. Improper drainage of waste water
5. Lack of sanitary storage space for clean linen
6. Submerged water inlets at washers, soap tanks, and set tubs

Laundry Personnel (22%)

1. Lack of training program for laundry personnel
2. Lack of personnel health program for laundry employes
3. Absence of trained supervisory personnel
4. Poor over-all supervision of laundry

Laundry Production (14%)

1. Proper temperature of water not maintained
2. Lack of sufficient hot water
3. Poor distribution program for clean linen
4. Lack of uniformity in using soaps and bleaches, causing skin irritations

Fire and Safety (12%)

1. Lack of a safety program within the laundry
2. Laundry is physically located in an unsafe place
3. Inadequate fire and safety equipment
4. Moving machinery not guarded

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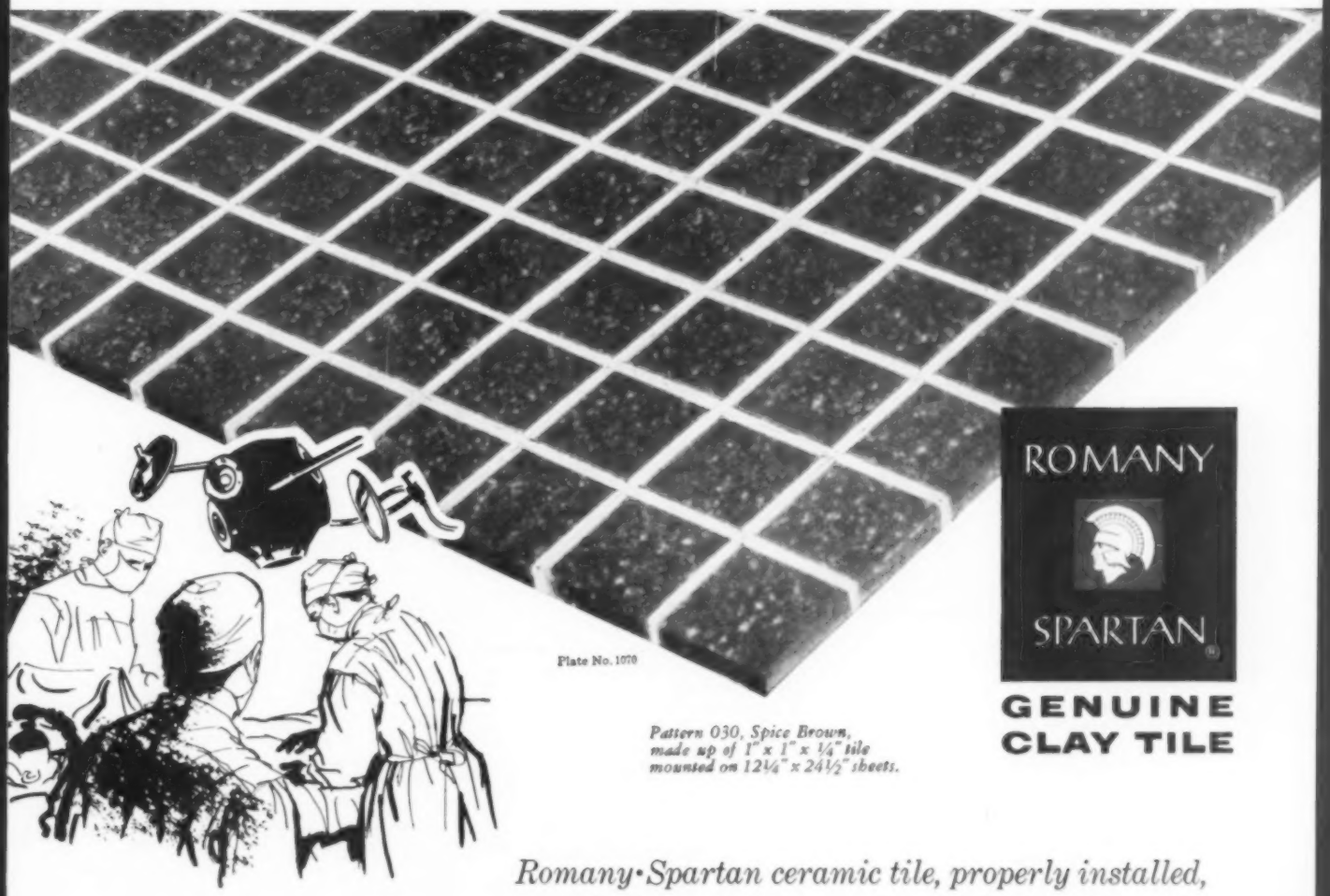

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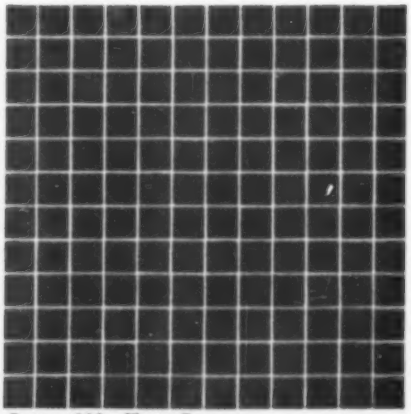

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Question 7. What are the five greatest problems found in general sanitation in hospitals?

The diverse response to this question made it necessary to group the 74 answers in six areas. These groupings, together with the percentage of responses falling into each of the respective groups, are shown here.

This listing of the deficiencies indicates that, again, most of the faults could be corrected with a minimum of capital investment.

Question 8. In what ways can hospitals better cooperate with state and local public health agencies?

The range of answers to this question was from, "We have excellent cooperation," to, "There is absolutely no common understanding between hospitals and public health agencies." However, for the most part, the indications were that hospitals and public health agencies need a two-way education program to make each aware of the objectives and services rendered by the other.

Some of the comments received in response to this question are listed as follows:

"Invite inspection by public health personnel and follow recommendations."

"Hospital personnel and administrators should become members of local health advisory councils."

"Hospitals should work out referral system with local health agencies for follow-up of released patients."

"Hospitals should invite local public health nurse to attend regular monthly meetings of the nursing staff to enable the public health nurse to know of changes in hospital nursing practices and policies."

"Invite local health officers to come before the hospital nurses at regular staff meetings to discuss topics of public health, such as quarantine, city water supply, sewage disposal."

"Recognize that inspection reports are for one purpose, *i.e.* to bring about improvement in the medical and nursing care of the patient."

"Administrators and boards should acquaint themselves with health department problems and hold frequent conferences to reach a common understanding."

"Hospitals should conscientiously use the information, services and facilities available to them in a joint effort to improve their institutions."

"There should be a closer relationship between hospitals and health agencies which will serve to point out that the inspection and licensing programs are *minimum* standards that should be accepted by the institution as part of its basic policy for the protection of the health, welfare and safety of the patients."

These comments, I am sure, will indicate that the public health agencies on all levels are deeply interested in the quality of patient care administered in the modern hospital. It seems to us that, in these agencies, hospitals could find not only basic understanding, but also a friend. ■

Question 6:

Administrative (27%)

1. Use of operating rooms for deliveries
2. Nonsegregated maternity departments
3. Use of labor rooms for deliveries
4. Lack of administrative system to refer patients to health departments for follow-up
5. The introduction of infant clothing from outside the hospital without proper sterilization
6. Lack of written procedures
7. Lack of self-discipline by doctors
8. Visitors not controlled

Educational (7%)

1. Lack of inservice training program
2. Lack of parent teaching program in the case of the newborn
3. Poor sterile technics carried on by doctors and nurses (gowns and masks)

Personnel (16%)

1. Lack of trained personnel to staff obstetrical and nursery departments
2. Lack of individual care for infants
3. Lack of pediatric supervision of the newborn

Sanitation and Housekeeping (18%)

1. Improper formula preparation technic for terminal sterilization
2. Housekeeping equipment used in obstetrics not used for that department only
3. Lack of handwashing by nursing personnel between baby handling

Physical Plant (25%)

1. Overcrowded nurseries
2. Lack of isolation nursery for suspect cases
3. Lack of conductive floor in delivery room
4. Poor ventilation and temperature control
5. Absence of premature nursery
6. Lack of storage space for sterile supplies
7. Poor facilities available for examining and treating babies in nursery
8. Lack of equipment in normal nursery

Miscellaneous (7%)

1. Lack of adequate facilities for the care of indigent obstetrical patients
2. Little care given to developing studies in the prevention of premature births

Question 7:

Sanitation and Housekeeping (30.26%)

1. Lack of organized insect and rodent control program
2. Lack of general cleanliness
3. Poor methods of storage and disposal of garbage waste
4. Poor dishwashing technics
5. Poor sanitation practices among food handlers
6. Improper handling of ice, food and other supplies used for human consumption
7. Need for adequate dust control program
8. Need for improved methods for terminal care of patient units

Physical Plant and/or Equipment (25%)

1. Inadequate lighting in the operating room
2. Abundance of cross-connections or back siphonage conditions owing to lack of supervision of plumbing installations
3. Faulty mechanical ventilation
4. Absence of fire and safety equipment and precautions
5. Hazardous electric wiring
6. Overcrowded patient areas
7. Lack of adequate handwashing facilities for hospital personnel and doctors
8. Antiquated food production equipment to support proper food service
9. Facilities for bedpan sterilization not always adequate
10. Antiquated buildings that make maintenance and housekeeping almost impossible

Administrative (17.10%)

1. Lack of written instructions outlining procedures for handling infectious materials
2. Failure to inspect and tag fire extinguishers routinely
3. Absence of organized health program for hospital employes and auxiliaries
4. Lack of segregation of patients by clinical department
5. Excessive noise and confusion
6. Clearly defined policies restricting patients from work areas
7. Need for better food management

Engineering (10.52%)

1. Mechanical dishwasher installations have steam line attached to wash vat rather than to the rinse line
2. Venting of inside rooms in old buildings
3. Inadequate maintenance of screens, windows and doors
4. Proper utilization of storage space

Education (9.21%)

1. Instruction in isolation technic needed for all levels of personnel
2. Necessity for inservice training program in all departments

Miscellaneous (7.89%)

1. City water not approved for consumption by state health department
2. Lack of foresight in new construction
3. Poor practice in some cases of hospital owned and operated water supply and sewage disposal system
4. Indiscreet use of detergents and soaps on floors, causing accidents
5. Lack of properly trained housekeeper and housekeeping personnel

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Staff Organization Creates These Problems

Should all doctors have staff privileges? Why are staff appointments made for one year only? Is membership in the A.M.A. required for appointment? What is the position of general practitioners? These are some of the questions asked at a recent hospital institute which indicate the kind of problems that worry administrators today

Lucius W. Johnson, M.D.

THE subject of a recent institute for hospital administrators was "Organization of the Medical Staff," and during a panel session participants submitted to panel members questions on phases of the subject that are of especial concern to them.

In hospitals as elsewhere, trends go in cycles and it is interesting to note how the questions at administrative institutes cover different parts of the field in different years. At this session last year, the queries dealt largely with accreditation. This year accreditation was the subject of only one question.

Following are some of the questions asked by the group with the answers.

1. Why is it advisable to have all members of the medical staff sign the by-laws?

When the physician signs the application for staff membership he agrees to the statement in it that he will abide by all the rules, regulations and by-laws of the hospital. His signature on the master copy of the by-laws indicates that the precepts he has agreed to obey have been made clear to him. The by-laws are the foundation of the ethical and professional relations of the staff members to one another and to the hospital.

2. The only hospital in my area has a closed staff. Does this fulfill its obligations to the community and to the profession?

Some hospital authorities define a closed staff as one in which all the professional services are provided and controlled by the organized active staff. This type of organization is designed to provide the best clinical care of its patients, also safety from exploitation. If ably administered, with conscientious control of the clinical work by the medical staff, it fulfills its obligations to its patients and to the physicians on its staff.

What are the obligations of a hospital to a community and to the medical profession? They vary with its nature, *i.e.* government, church, proprietary, voluntary, specialty; and also with the type of community. Many people believe that every doctor should have complete hospital privileges. Others say that some doctors do not desire hospital privileges and that some doctors should not have them. A careful study of local conditions would be necessary before one could give an intelligent answer to this part of the question.

3. What is the best method of selecting heads of clinical departments? Should the appointment be for one year or longer?

Several methods are in use: (1) Heads of departments are selected by the departmental groups. This is seen in several large university hospitals. (2) They are appointed by the chief of staff and approved by the governing board. (3) They are chosen by the governing board. This has been observed in church and government hospitals. All these methods have worked well.

In voluntary, nonprofit hospitals of medium size, the heads of departments may be appointed by the chief of staff, or selected by vote of the whole staff, and approved by the governing board. Both methods are widely used.

Appointment for one year is advised if the department group is large enough to provide several doctors of suitable ability so that they can rotate. If there is one outstanding physician who enjoys the respect, good will and confidence of the group, it might be well to reappoint him. I have seen embarrassing situations when a department head had served beyond his prime and it became difficult to blast him out when this became necessary.

4. Must all members of the medical staff be members of the American Medical Association?

Several years ago the United States Department of Justice brought it to the attention of the American College of Surgeons that if such membership was a requirement for an approved hospital it might make the College liable for violation of the law against trusts and monopolies. To avoid the danger the Joint Commission now requires only that staff members be eligible for membership in local and national professional organizations.

This requirement recognizes the fact that a considerable number of extremely competent doctors do not want to belong to medical societies or specialty boards. They just do not want to have anybody telling them what to do and what not to do. They are individualists, not teamworkers, and some of them are very able.

5. Why should staff appointments be for only one year?

Many hospitals have found this to be a wise provision. It has been observed that a license to practice medicine and a certificate from a specialty

board do not always guarantee good ethics, good morals, and the ability to work in harmony with people on all levels in the hospital. If doctors fall below acceptable standards the hospital can ease them out of the group by failing to reappoint them for the next year. This procedure must be clearly outlined in the by-laws.

It has also been found that the appointment for one year acts as a continuous incentive for each member of the staff to show his loyalty to the hospital in his daily work. The doctor's livelihood is more and more dependent on his hospital privileges. To retain those privileges he must conform to the rules. There are daily problems in which the physician and the hospital share responsibility and liability. The one year rule helps the physician to remember the interests of the hospital as well as his own when making decisions about those common problems.

6. How can the hospital administrator influence staff selection?

While selection of the medical staff is not the prerogative of the administrator there are many ways in which he can exercise considerable influence.

1. He can, by his character, his conduct of affairs, his relations with people in the hospital and in the community, earn the respect and confidence of the members of the medical staff. Then they will seek his advice about important matters and will be influenced by it.

2. When applicants for medical staff privileges are being considered he should use whatever influence he has to make sure that applicants' training, ability, ethical character, willingness to conform to the rules of the hospital and ability to work in harmony with others are considered carefully.

3. He can recommend a conference, headed by the chief of staff, during which the new member can sign the by-laws and be informed about his privileges and the policies of the hospital. This is an excellent occasion for him to meet the heads of the hospital departments and to learn from them about the assistance their departments are prepared to offer him.

4. He can point out to the medical staff the advantages of making staff appointments for one year only, and the importance of a probationary period for newly appointed staff members during which their work is appraised carefully by a competent staff committee.

7. What is the best type of medical audit for a hospital that has never had one and isn't sure that it wants one?

I suggest that you write to two or three independent medical auditors, preferably not in your immediate neighborhood, and ask each one for an outline of the type of audit he is prepared to make. Submit their replies to the medical staff and to the governing board and ask them to choose an auditor and engage him.

It is quite likely that the independent auditor, in his final report, will recommend that the hospital adopt one of these two plans:

1. That the hospital develop its own continuous audit, conducted by a competent committee of the medical staff. Many excellent hospitals are now doing this and they find it extremely valuable in controlling the quality of clinical work.

2. That the hospital affiliate with the Commission on Professional and Hospital Activities, First National Bank Building, Ann Arbor, Mich. This is a group of 87 hospitals in 22 states, with about 800,000 discharged patients annually. When a patient is discharged from one of the member hospitals the medical record librarian makes out a code sheet with factual data concerning the case. The sheet is sent to the commission's headquarters where the data are transferred to punch cards which are machine processed. The commission sends back to the hospital five monthly and eight semiannual reports which show in detail the quality and success of the hospital's clinical work. These reports provide material for study and discussion by the medical staff and the governing board, a most effective way of controlling the clinical work.

8. Our hospital has recently been opened, with all general practitioners. How long do we have before the accreditation people will be around to criticize us?

As a hospital administrator you should know about the four requirements for a visit by the examiner for accreditation. They are: (1) You must have at least 25 beds. (2) You must have been in operation for one year. (3) You must be listed with the American Hospital Association. (4) You must request the examination.

For specific information about requirements for accreditation, you may address an inquiry to the Joint Commission at 660 Rush St., Chicago.

9. Several general practitioners in our hospital resent any control of their work by staff rules. They talk of organizing their own hospital. Could this be successful?

It has been done in several cities, sometimes successfully, sometimes not. Frequently these splinter groups take the name Doctors Hospital. "I got fed up with being pushed around by specialists, and having Sisters look over my shoulder while I worked," a spokesman for one of those groups told me. "We're going to have a hospital where we general practitioners can do anything we want to do. No specialist will ever darken our doors," said another.

I have surveyed hospitals that started out with that chip-on-the-shoulder attitude several years earlier. The usual experience had been that there were occasions when a specialist was needed. Also, there was usually a member or two of the group who felt that some control of the quality of clinical work was desirable, and so there had been gradual upgrading of the quality of the clinical work and of its controls. In several cities hospitals that were started by dissatisfied groups have developed into excellent institutions, but it takes time.

10. Should a hospital administrator have a medical adviser and should that be a confidential relation?

Dr. W. W. Stadel, recently president of the California Hospital Association, expressed the idea that a hospital administrator, and especially a young one, should have a medical adviser. He recommends that the adviser be a highly respected member of the medical staff, to whom the administrator can go for advice and to whom he can make suggestions on administrative matters.

It is not necessary to advertise this relation widely, but it certainly should not be concealed. That would make both the physician and the administrator vulnerable. In some important matter with divided opinions a disgruntled member might stand up in staff meeting, advertise the adviser relation, and accuse either the physician or the administrator of being a stooge for the other. On the other hand it might add to the stature of the administrator if it were understood that he frequently sought the advice of an outstanding member of the staff. ■

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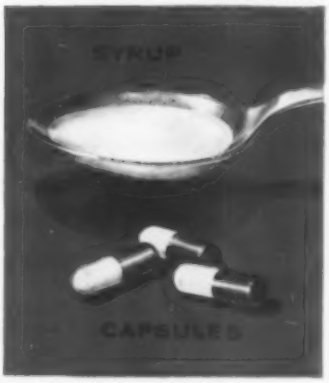

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SUPPLIED: Capsules sodium novobiocin, each containing the equivalent of 250 mg. of novobiocin—vials of 16 and 100—and as an orange-flavored syrup (aqueous suspension), in bottles of 60 cc. and 473 cc. (1 pint). Each 5 cc. CATHOMYCIN Syrup contains 125 mg. (2.5%) novobiocin, as calcium novobiocin.

*Complete bibliography available on request.

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Deanol: a Biochemical Stimulant

Studies indicate that this drug can be recommended for clinical trial in the treatment of such conditions as schizophrenia, periodic headache, chronic fatigue states, and bronchial asthma

PFEIFFER and Jenney[1] have found that the tertiary amines arecoline, pilocarpine, and eserine will inhibit the conditioned avoidance response in rats protected peripherally with atropine methyl nitrate. Arecoline, when used in atropine methyl nitrate-protected schizophrenic patients, will produce a "lucid interval" similar to that of amobarbital or carbon dioxide.[1,2] These findings initiated a new research program[3] designed to find longer acting parasympathomimetic agents or precursors of acetylcholine which might affect the central nervous system. Two quaternary nitrogen compounds, acetylcholine and methacholine, probably owing to their slow transit across the blood-brain barrier, are without effect on the conditioned avoidance response. Furthermore, Mayer and Bain[4] have used the tertiary and quaternary analogs of a convulsant, fluorescent acridone, to delineate the blood-brain barrier, and Koelle and Steiner[5] find that the quaternary nitrogen analog of a phosphate ester of thio-choline inhibits the peripheral but not the cerebral cholinesterase, while the tertiary amine congenor inhibits both.

Gellhorn[6] has studied the central nervous system effects of the very simple quaternary nitrogen compound TEA (tetroethylammonium chloride). He finds that as long as the TEA is infused slowly so as to maintain blood pressure constant the pathways of the CNS are not modified. Unna[7] has found that atropine methyl nitrate (a quaternary) does not have the usual atropine effect on the Parkinsonian tremor of "tremor monkeys."

These numerous independent observations are compatible with the concept that choline might be relatively inadequate as a precursor of cerebral acetylcholine because of its limited transport across membranes. The membranal barriers are not only the blood-brain barrier, but also the neuronal membranal and perhaps even the mitochondrial membranal barriers. Williams[8] has found that isolated mitochondria with their contents of choline oxidase will not effectively oxidize choline *in vitro* until the mitochondrial membrane is ruptured.

The lack of pharmacological potency of choline chloride in man is evidenced in the treatment of patients with liver disease, where as much as 10 gm. per day may be given without any discernible acetylcholine-like pharmacodynamic effect.[9] Since choline is a methyl donor, one might expect the tertiary analog to be readily formed *in vivo*. However, choline as a methyl donor has been found to go to dimethyl glycine by way of the intermediate, betaine [10, 11, 12, 13] and, therefore, it may not provide a tertiary amine precursor for the synthesis of cerebral acetylcholine. For this reason, possible tertiary amine precursors of acetylcholine, including 2-dimethylaminoethanol (Deanol), have been studied extensively in mammals, including man, in these laboratories. Deanol can be likened to a streamlined molecule of choline.

Previous Studies on Deanol: The pertinent pharmacological publications on Deanol can be summarized briefly as follows: Krayer, et al[14] find that Deanol in a dose of 200 mg./800 ml. volume counteracts the cardiac failure produced by pentobarbital sodium. Biochemical studies by Korey, et al[15] indicate that Deanol is acetylated at the same rate as is choline by choline acetylase, and that acetyl-Deanol has less than 0.01 of the activity of acetylcholine on the frog rectus preparation. In chronic feeding experiments on growing chicks on a choline-deficient diet, Jukes and Oleson[16] report that Deanol will partially substitute for choline. In a Neurospora cholineless mutant, however, Jukes and Dornbush[17] show that Deanol substitutes completely for choline as a growth factor. Reid,[18] working with choline-deficient guinea pigs, finds that Deanol will substitute completely for choline, whereas aminoethanol, N-methylaminoethanol, betaine, dimethyl glycine, and methionine are ineffective.

Demers and Bernard,[19] working with growing ducklings on a choline-deficient diet, found that Deanol substitutes completely for choline as a growth factor.

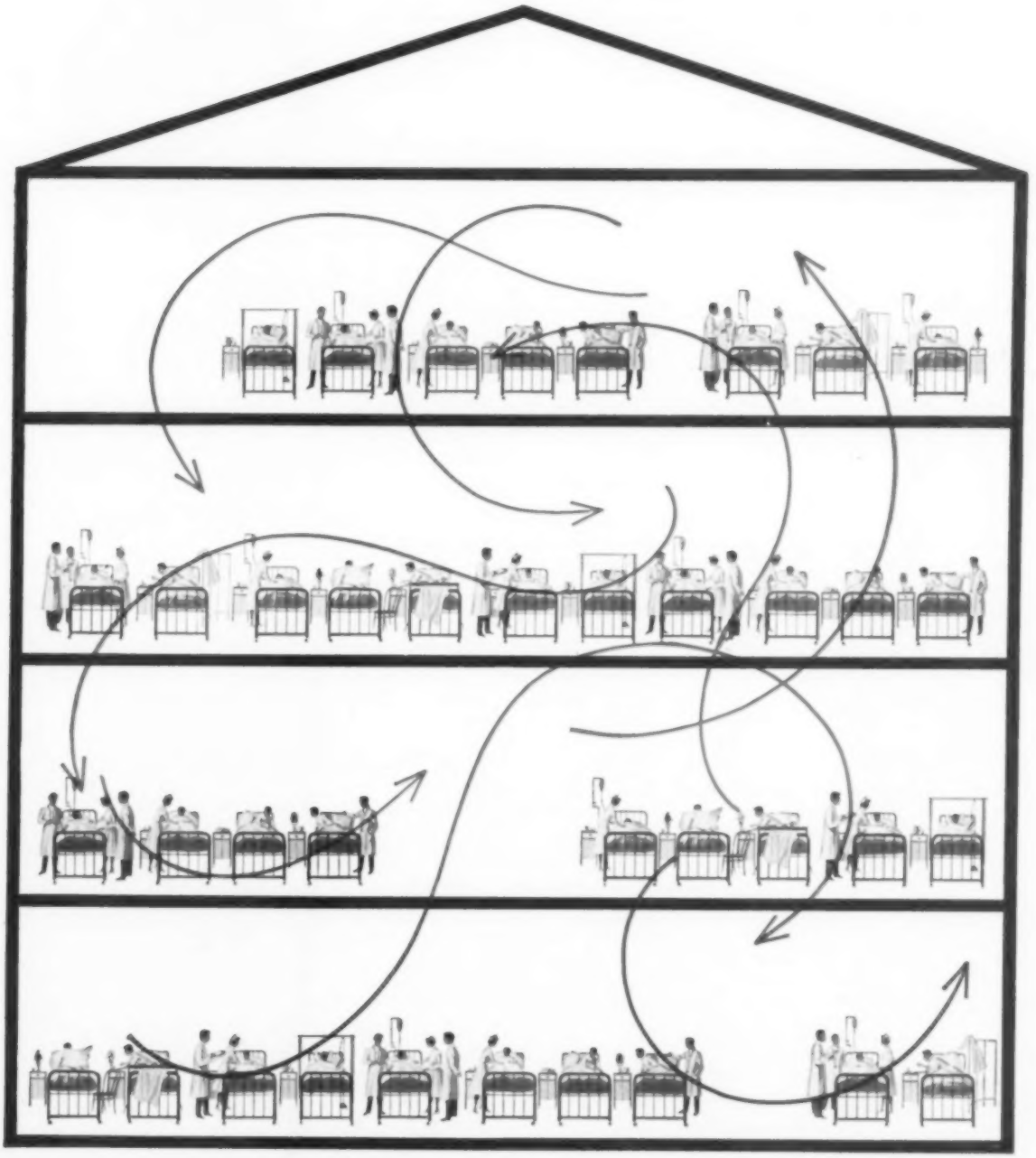
Numerous salts and esters of Deanol have been synthesized and tested. When calculated on the content of Deanol base, the p-acetyl amino benzoate salt is the least toxic. The acute toxicity is comparable to that of choline chloride which means that more than a gram per kilogram of body weight is needed to kill a mouse by intraperitoneal dosage and more than 3.5 grams per kilogram of body weight is needed orally to be lethal.

Acute Pharmacology of Deanol: In acute pharmacological experiments Deanol is less potent than is choline with certain exceptions. Blackmore[20] has shown in the rat that Deanol is more antidiuretic, which action is interpreted as greater activity of Deanol in releasing the antidiuretic hormone from the posterior pituitary gland. Comparable action could not be demonstrated in the dog with intravenous doses of 7.5 mg./kg., and this dose had no effect on the renal plasma flow or the glomerular filtration rate.

Koningsmark, Killam and Killam,[21] in neuropharmacological experiments, find that Deanol increases the potentials of the reticular formation and overcomes barbiturate induced depression of the reticular formation.

Kiplinger, Swain and Brody[22] have found that treatment with Deanol doubles the resistance of the heart to pentobarbital and also antidotes the

Deanol is the generic name for "Deaner" Riker, a brand of 2-dimethylaminoethanol.



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cardiac effect of quinidine and sodium fluoracetate.

Effects of Prolonged Intake of Deanol: In contrast to the inactivity of Deanol in acute dosage, the prolonged intake of Deanol at high doses produces spontaneous epileptiform seizures in the mouse and the rat and also makes them susceptible to audiogenic seizures. This activity is most easily demonstrated by infusing pentylenetetrazol (Metrazol) in the mouse (Table 1).

A more extensive study shows the threshold for electroshock, strychnine and amphetamine to be significantly elevated. The threshold for pentylenetetrazol was again specifically lowered by Deanol, whereas choline is inactive (Table 2).

Since a month of treatment is needed to produce epileptic activity in the mouse the question arises as to whether this is a permanent CNS defect from Deanol treatment. Accordingly, the effect of Deanol on pentylenetetrazol threshold was again reaffirmed and the mice were then returned to tap water. Groups of mice were tested weekly until their thresholds had returned to normal (Table 3).

A month was required for the animals to return to normal threshold! Chronic toxicity studies in rats and dogs do not disclose any deleterious effects.

Trials in Patients: Since Deanol may occur in natural foods and may regulate the synthesis of acetylcholine, the cautious clinical trial of various salts of Deanol was initiated. These trials were undertaken to ascertain the stimulant dose of Deanol and to obtain the beneficial therapeutic effect of the possible increased synthesis of acetylcholine in the body. Total oral doses as 10 to 30 mg. daily of Deanol base (given as the para-acetyl amino benzoate salt) per day produce, in

Table 1—Effect of Choline and Deanol on Convulsant Thresholds When Fed to Mice as 0.03 M Solution in Drinking Water for 31 Days

Ten mice were used in each group, and 0.5 per cent pentylenetetrazol was infused intravenously at the rate of 0.05 ml./10 sec. $t = 5.3295$ for difference between means of choline and Deanol. $p = <0.001$.

Treatment	Lethal Convulsion (ml/mouse)
Controls	0.525 ± 0.09
Choline	0.525 ± 0.10
Deanol	0.250 ± 0.11

Table 2—Convulsant Thresholds in Groups of 10 or More Mice Treated With 0.03 Molar Choline or Deanol in Their Drinking Water for Two to Three Months

		Water Controls	0.03 M Choline	0.03 M Deanol
Electroshock 0.03 sec. duration	Convul. Dose 50 ± stand. error in milliamperes	6.86 ± .22	7.75 ± .26‡	8.91 ± .32*
Pentylenetetrazol 0.5% T. I. V. I.	Mean Convul. Dose ± Stand. error mg./kg.	92.1 ± 4.7	88.1 ± 5.3	47.5 ± 6.6*
Strychnine sulf.	Mean Convul. Dose ± Stand. error mg./kg.	1.01 ± .025	1.00 ± .027	1.30 ± .10*
d l-amphetamine	LD-50 ± Stand. error mg./kg.	12.2 ± 2.4	16.7 ± 2.4	>30.0*

T.I.V.I. = Timed intravenous infusion at the rate of 0.05 ml./10 sec.
*Indicates statistically significant difference from both choline and water controls.
‡Indicates statistically significant difference from water controls and D treated group.

Table 3—Lowering of Pentylenetetrazol Threshold in Deanol-Treated Mice and Time Required for Return to Normal Threshold

	Normal Mice	Choline Mice	Deanol Mice
Threshold (mg./kg. ± S. E.)	71.4 ± 5.2	73.3 ± 5.4	27.3 ± 2.4
Off Deanol for 3 days			40.2 ± 4.9
Off Deanol for 9 days			44.3 ± 3.0
Off Deanol for 21 days			55.2 ± 8.6
Off Deanol for 30 days			76.0 ± 9.7

Technics the same as in Table 2. Mice on choline, Deanol or tapwater for three months.

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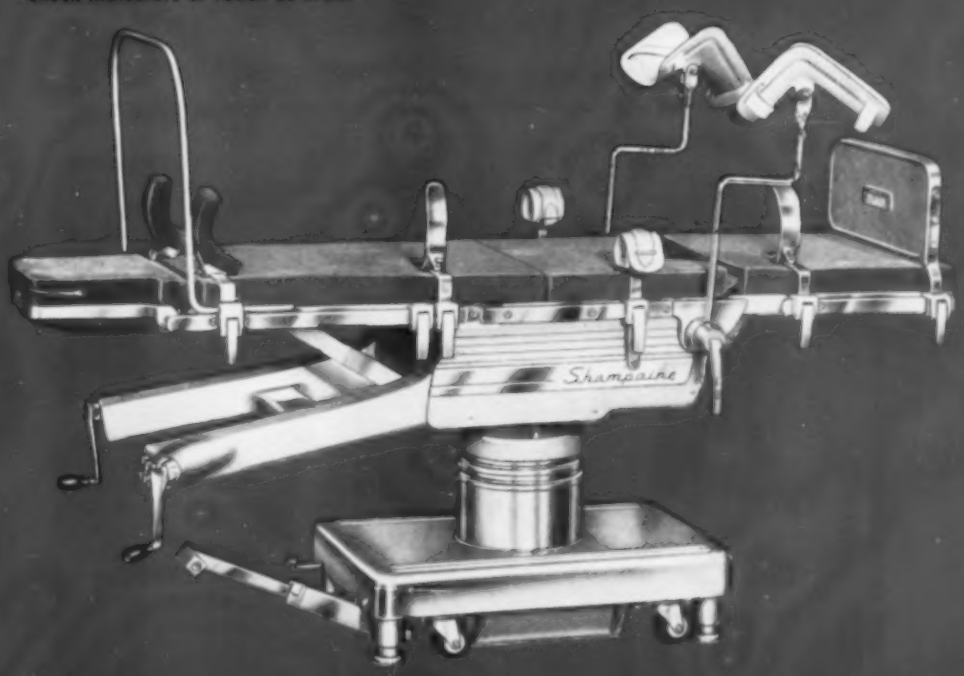

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7 to 10 days, a mild and pleasant degree of central nervous system stimulation which is characterized by lessened daytime fatigue and sounder sleep, but fewer hours of sleep are needed. Doses above 25 mg./day may result in increased muscle tone (most evident in the neck, masseter and quadriceps muscles) and insomnia. (This observation contrasts sharply with that for choline, where 10 gm. per day is devoid of stimulant action.)

Comparative Passage of the Blood-Brain Barrier: Carbon^{14} labeled Deanol and choline studies in the mouse show that choline is oxidized more extensively than Deanol, while Deanol attains higher levels in the lipid and acid soluble fractions of the brain. Label from Deanol was retained by the brain, while label from choline was continually lost over the time period studied.

Controlled Trials in Volunteer Subjects: Comparative trials with a placebo under double blind test conditions in normal man showed that a statistically significant change in sleep habits, increase in mental concentration, and increase in muscle tone is produced by 20 to 30 mg. per day of Deanol. In an additional six weeks of trial, 25 out of 35 subjects noted a definite CNS stimulation with doses of 20 to 30 mg. per day of Deanol.

Trials in Schizophrenic Patients: Clinical trial in 70 chronic schizophrenic patients for an average period of nine months showed Deanol therapy at a dose of 50 mg. per day to be comparable in effect to that of the phenothiazine drug "Vesprin" which was studied concomitantly in 30 patients. From preliminary clinical studies Deanol is recommended for clinical trial in the treatment of schizophrenia, periodic headache, chronic fatigue states, functional bowel distress, bronchial asthma and Raynaud's disease. Biochemical adjuvants which increase the effectiveness of Deanol are pyridoxine, vitamin B-12, and possibly pantothenic acid.

Dosage and Administration: The initial daily dose is 12.5 to 25 mg. daily for 3 days, taken in the morning. This dose should be increased at three-day intervals until an effective dose is obtained. This dose should be administered for two to four weeks and then reduced slowly to a smaller one effective for maintenance. While the usual daily maintenance dose is from 25 to 75 mg. of Deanol daily, this must be adjusted to the individual patient. The effects of Deanol in stimulating mentation and in elevating mood may not be apparent immediately, and increasing doses should be administered for at least three weeks before the patient is adjudged an unsuitable subject for Deanol therapy. (In addition, the patient may be advised to take a daily multivitamin which contains at least 1.0 mg. pyridoxine.)

Patients with periodic headache, chronic fatigue, Raynaud's disease, collagen disorders, petit mal epilepsy or functional bowel distress will usually be relieved by a dosage of 12.5 to 50 mg./day.

With this dosage regime the patient may note a slightly increased lethargy during the first few days. Within a week this is superseded by a feeling of greater affability of mood, and increased daytime energy. Characteristically, the need for sleep is decreased and the patient may find that six to seven hours sleep each night is sufficient. This may be regulated naturally by clear-minded awakening before the alarm clock rings. Physicians and psychiatrists report that the patients are more affable and develop a more outgoing personality characterized by greater insight, open discussion, and occasionally frank criticism. Powers of mental concentration may be increased to the point of absent-mindedness.

Physiological changes which may be noted during Deanol therapy are an increase in the warmth of the ex-

tremities, better skin color of the face and hands, slight increase in perspiration, increased tolerance to a cold environment, decrease in pulse rate, slight increase in blood pressure to a more median level. The eyes and nasal mucosa may become drier while salivary secretion may be slightly increased. Muscle tone may be noted subjectively to increase. Bowel habits may change toward a slight constipation during the first few weeks of therapy, but this is gradually superseded by more normal and regular bowel function.

For patients with severe depression or agitated depression, such as chronic schizophrenics, the usual daily maintenance dose for long-term therapy appears to be 50 to 75 mg. However, doses should be larger for the first week and then reduced gradually to an individually determined amount. Oral doses up to 350 mg. per day have been given without serious side effects. In severely depressed or uncooperative patients it may be advisable to administer Deanol by subcutaneous or intramuscular injection during the first one or two weeks of treatment. At this writing as much as 40 mg. has been given intravenously in a single dose with resulting stimulation and without production of untoward effects. It is probable that much larger doses can be injected with safety.

Contraindications: Deanol therapy appears to be relatively contraindicated in grand mal epilepsy and in mixed epilepsy with a grand mal component. When it is used in these states the dosage should be increased slowly.

Side Effects: Since Deanol has been found in animal bodies, it is probable that it also occurs in human bodies. As a naturally occurring substance, Deanol should not give rise to sensitization reactions when used in therapy. In confirmation, drug sensitizations have not occurred in any patient to date. The reactions which have been encountered to date have been due to overdosage and have responded promptly to reduction of the daily intake of Deanol.

Reactions which have occurred with Deanol therapy have been mild and entirely attributable to (a) a too rapid increase in dosage, or (b) overdosage. Reactions under (a) are, in the order of their frequency, (1) dull occipital headache, early in therapy, and (2) constipation. Reactions due to (b) are, in their order of frequency, (1) muscle tenseness in the neck, masseter and quadriceps groups, (2) insomnia, (3) itchiness of the skin or scalp, (4) rarely, postural hypotension, and (5) very rarely, weight loss.—CARL C. PFEIFFER, M.D.

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QUICK APPLESAUCE PINWHEELS

Total yield: 90-96 pinwheels
Number of portions: 45-48
Size of portions: 3 oz.

Type and size of pan:
2 (25½ by 17½ by 1¼ inch)
Portions per pan: 22-24

Ingredients	Measure
Filling:	
Canned applesauce	1 No. 10 can
Cornstarch	1 cup plus 2 tbsp.
Butter	¾ cup
Honey	2 cups
Raisins	4 cups
Cinnamon	as desired
Dough:	
Biscuit mix	6 qts.
Sugar	1 cup
Milk	1½ qts.

Blend cornstarch into applesauce; add honey and butter. Heat applesauce mixture and allow to boil one minute. Add raisins, cool. Add sugar, then liquid to biscuit mix to form stiff dough. Divide dough into eight 22 oz. portions; roll out in oblong 15 by 11 by ¼ inch. Spread each rectangle with two cups applesauce mixture. Sprinkle generously with cinnamon. Roll up. Cut in 1 inch slices. Place slices close together in baking pan, cut side up. Bake in hot oven, 400 degrees, for 30 minutes. Serve hot.

QUICK APPLESAUCE PINWHEELS

Photographs, courtesy Processed Apples Institute, Inc., New York

PREPARED apple products not only add to the popularity of hospital menus, but are labor saving and therefore cost saving. They are an almost inexhaustible source of menu surprises that help enhance hospital meals. Applesauce, which can be used plain as a dessert or meat accompaniment, can be given a gourmet touch by mixing in a little chopped ginger or ginger marmalade and serving it with cream. Minted applesauce, made by flecking in a small amount of finely chopped fresh mint, complements roast lamb.

For the children's ward, applesauce can be sprinkled with crushed peppermint candy or crumbled peanut brittle. Apple juice, chilled or served at room temperature, is a welcome mid-afternoon refreshment. Mixed half and half with prune juice, it adds a supplement of vitamins and minerals to the diet.

Baked acorn squash, filled with applesauce mixed with brown sugar and lemon juice, adds interest to a simple recipe. Easy to prepare and good to eat are "Saucy Sweets." Arrange cooked and peeled sweet potatoes in a baking pan. Spread with a combination of applesauce, dark brown sugar, and lemon juice. Dot with butter or margarine, and sprinkle with chopped walnuts and mace. Bake in a moderate oven for about 40 minutes.

A zesty relish for hot or cold meats combines chopped fresh cranberries, canned apple slices, and chopped raisins. The mixture is sweetened with granulated sugar and moistened with lemon juice. Chilled for several hours before it is served, this relish adds color as well as flavor to the meal.

Baking uses of applesauce and apple slices are many. Nearly every dieti-

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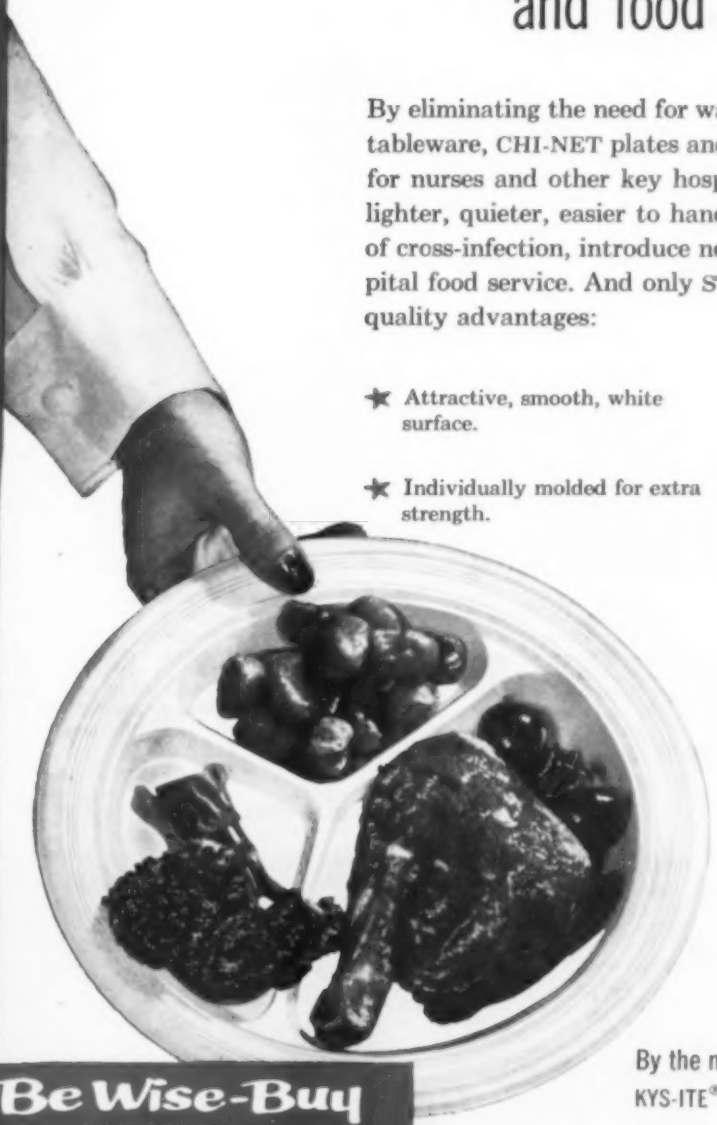

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tian has some of them in her file of special recipes, from a favorite apple pie to applesauce pinwheel rolls for a breakfast or luncheon treat. Bland as well as appetizing desserts, such as cobblers and tortes, can be made with apple products. Combined with tapioca, coconut, gelatin or other fruits, apples provide a variety of popular ways of topping off a meal.

In entrees, canned apple products give the food operator an opportunity to serve familiar favorites with her own special touch. Deep dish chicken pie with apple slices as one of the ingredients is an example. Apple slices can also be added to curried chicken for a new flavor combination. Apple juice can be used to baste baked ham, with the remaining juice spooned over each serving. For a Friday menu in the staff cafeteria, a "Shrimp Crowned Curried Rice" combines applesauce, raisins, curry powder, and oregano with cooked rice. The dish is topped with cooked shrimp, brushed with melted butter and then baked for 45 minutes. ■

DEEP DISH CHICKEN APPLE PIE

Total yield: 38 pounds
Number of portions: 75
Size of portions: 8 oz.

Type and size of pan: 4 (19½ by 11¾ by 2½ inch) roasting pans

Amount per pan: 9½ lbs.
Portions per pan: 19

Ingredients	Measure
Chicken, roasting, disjointed	16½ lbs.
Salt	2 tbsp.
Pepper	2 tsp.
Monosodium glutamate	3 tbsp.
Flour	4 cups
Cooking oil	3 cups
Onions, sliced	19 med.
Chicken stock	7 qts.
Marjoram	½ tsp.
Salt	2 tbsp.
Pepper	2 tsp.
Canned apple slices	1 No. 10 can
Raisins, seedless	3 cups
Pastry dough	

Sprinkle cut parts of chicken with salt, pepper and monosodium glutamate; let stand 30 minutes. Dredge chicken in flour; sautée in hot fat until golden. Remove and divide among four roasting pans. Sautée onions in drippings until soft. Stir in flour until blended. Gradually stir in stock, stirring until smooth, boil one minute. Season to taste with marjoram, salt and pepper. Pour gravy over chicken in each pan. Divide apples, onions and raisins equally among pans. Bake in slow oven, 325°F. for 40 to 45 minutes. Remove from oven and cool. Before serving cover each pan with pastry, prick top and bake in hot oven, 400 degrees, for 25 minutes.

DEEP DISH CHICKEN APPLE PIE

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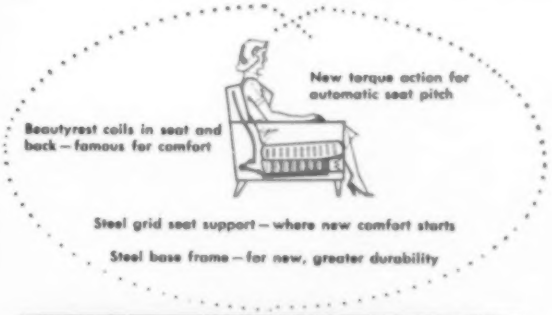

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Dietary Consultant Helps With Planning

An unexpected dividend provided by the food consultant service maintained by the Connecticut Hospital Association is the sound advice the consultant can give to hospitals and architects about the design and equipment of the dietary department — based on her experience with several hospitals

Jane Hartman and John T. Foster

UNDER provisions of a Public Health Service grant, the Connecticut Hospital Association employs a food service specialist to assist its member hospitals. In addition to counseling on food service practices, the specialist has been increasingly involved in architectural consultations about new dietary facilities throughout the state.

The experience has demonstrated that the food service specialist can play a useful role by providing (1) specialized dietary advice on design to the architect, (2) objective evaluation of the hospital's needs, and (3) guidance in the selection of food service systems and equipment, in general. As adviser to a group of hospitals, the consultant has the advantage of current information about a variety of solutions to common problems of a region.

When the "Project for Improved Personnel and Dietary Administration" was established it was not expected to include consultation on architectural problems. It was planned as a continuing service to hospital administrators and their dietitians that would emphasize proper technics of food purchasing, preparation and distribution. A major objective from the outset has been improved food service with maximum economy. But as the project gained acceptance among the 33 hospital administrators, it became clear to the consultant that architectural advice was not only needed but desired. As a result of outright grants from the Ford Foundation and even larger construction programs financed partly from Hill-Burton funds, some 15 of the Connecticut hospitals were engaged in expansions involving their dietary departments. As the new service began, it became clear that such guidance was particularly consistent with the original cost-saving goals of the hospital association.

Miss Hartman is food service specialist, Project for Improved Dietary Administration, Connecticut Hospital Association, New Haven, Conn. Mr. Foster is administrative assistant, Stamford Hospital, Stamford, Conn., and student in hospital administration, Yale University Program in Hospital Administration.

The Staff Must Define Goals

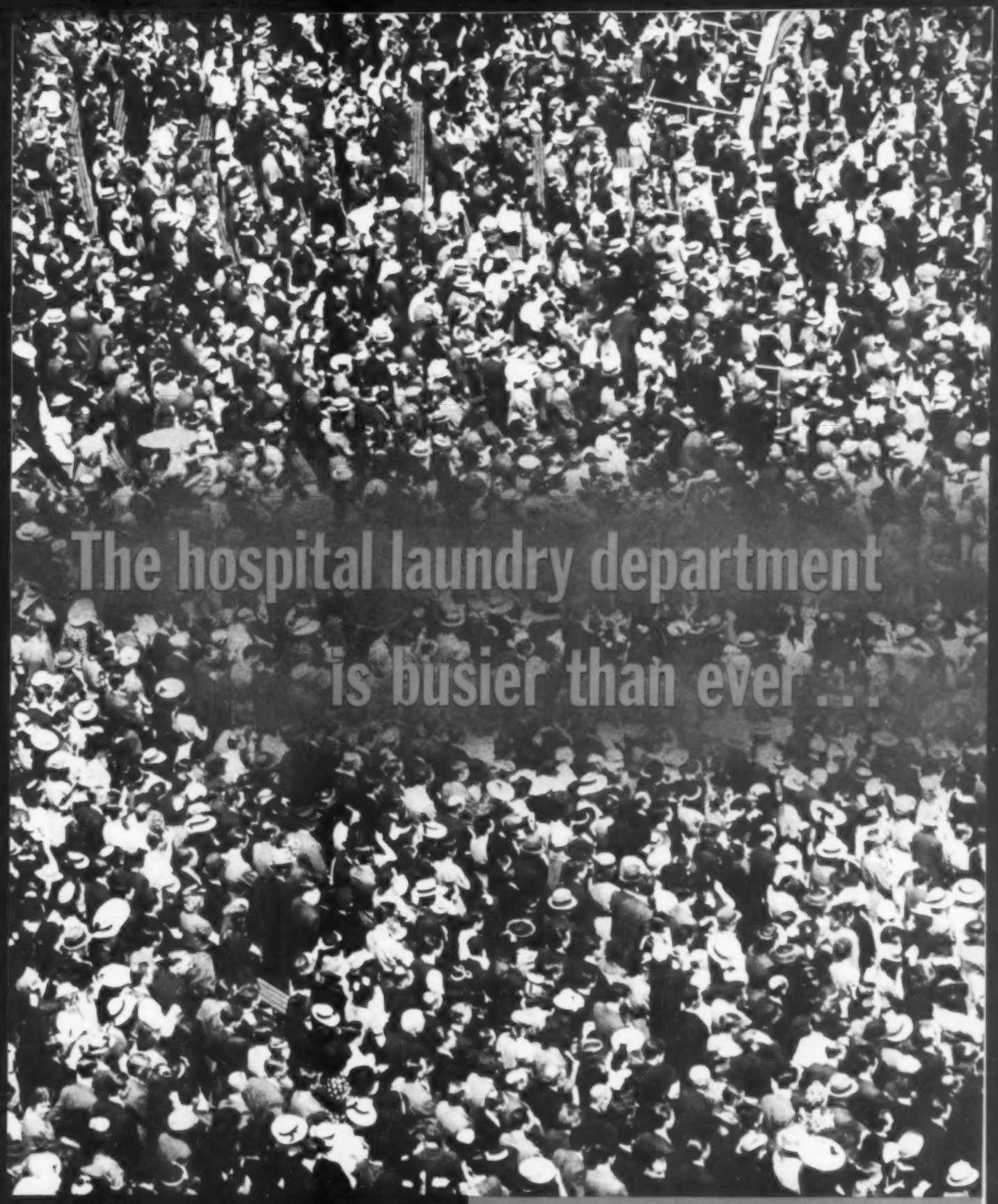
The architect designs a dietary department in accordance with the kind and extent of information he is given. How functional the design is in practice will depend in large part upon the degree that all persons involved – hospital administrator, dietitian and dietary staff – are allowed to use their imaginations and their experience in sound, collective planning. The internal staff, alone, can define its peculiar needs and goals as the bases upon which the architect can then suggest solutions from his drawing boards.

The food service specialist, it has been found in Connecticut, supplements this process with a third-party view. Without vested interest in anything except better dietary services (the specialist's services are available without extra cost nor does she represent equipment vendors), the specialist occupies the role of a mediator between architect, administrator and dietitian when opinions differ. Because she serves many hospitals with as many ways of doing things, the specialist is likely to be aware of current trends and of coming developments. In dietary administration, as elsewhere, theory is always in advance of practice. With careful study and evaluation of the rapidly evolving field of dietary equipment and of new food processing, the consultant has an opportunity to predict the kitchens of the future with a fair degree of accuracy.

When a dietary department is to be remodeled or a new facility constructed, it is customary (1) to survey existing practices of the hospital, (2) to profit by past mistakes, (3) to establish desired criteria of the future food service both quantitatively and qualitatively, and (4) to survey new developments both in the literature and by visits to new facilities elsewhere. In all four steps, the consultant can assist the hospital leaders in gathering and interpreting facts. Although the food service specialist consultant may have no greater dietetic qualifications than the resident hospital dietitian, she will always have the advantage in architectural planning because of her continuing contact with many hospitals.

Experiences of the food service specialist in Connecticut have been illuminating. Because the service was new, the specialist's involvement in building plans occurred in several cases after not only the architect but also independent food service consultants had submitted tentative plans. In one such case, the design as submitted proposed a complete circuit of the kitchen by each of the new "hot and cold carts." The project consultant was able to devise a far less circuitous route to save space and energies.

In a number of hospitals, help was requested in preparing equipment specifications. It was found in these cases that few administrators or dietitians were equipped to specify such



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The laundry is for the hospital. The hospital is for the people.
And there are more and more people every day.

Today, with hospital occupancy at an all-time high, there is greater need than ever for the vital service of the hospital laundry. Eventually, this growing demand results in a laundry that is *too* busy—overworked, understaffed, under-equipped, even obsolete. Fortunately, this is not always a problem of floor space, simply a matter of planning.

Helping your laundry continually offer better service to your hospital and your patients is our business at American. And it is a business we intend to be in for many years to come.

How long has it been since you've studied conditions in your laundry? Providing an authoritative answer to your hospital's present and future laundry needs is another way you get more from American.

You get more from American

The American Laundry Machinery Company, Cincinnati 12, Ohio

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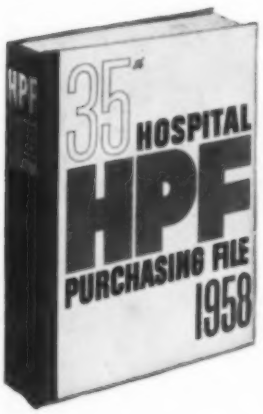


catalogs of suppliers most eager to serve you

Always turn to HOSPITAL PURCHASING FILE when you choose any equipment or supplies—either familiar items or those you buy only occasionally—for detailed information to help you compare and select. Here, all in one place, are the catalogs of manufacturers who are most eager to help you make wise buying decisions. Catalogs are grouped by hospital departments and simply, accurately indexed to help you find what you are interested in easily and quickly. Keep Hospital Purchasing File on your desk. Be sure your department heads use it to speed up product comparison. Below is a list of catalogs of equipment for special professional service departments.

turn to section FC

laboratory, pharmacy, sterilizing, diagnostic and other special professional equipment

Alberene Stone Corp. of Virginia

Aloe Co., A. S.

American Hospital Supply Corp.

Cambridge Instrument Co., Inc.

Chicago Surgical & Electrical Co. Division of Labline Inc.

Electric Hotpack Co., Inc.

Electro-Medical Laboratory, Inc.

Grand Rapids Sectional Equipment Co.

Haemoscope Corp.

International Equipment Co.

Macalaster Bicknell Parenteral Corp.

Macbick Co.

Sanborn Co.

Scientific Products Division, American Hospital Supply Corp.

U. S. Industrial Chemicals Co., Division of National Distillers & Chemicals Corp.

For additional information, use postcard facing Cover 3.

details as the gauge of metal most practicable for shelving, cabinets or cooking equipment. In one hospital engaged in building an entirely new kitchen, first equipment bids exceeded budgeted funds by 89 per cent. When the food service specialist was called upon for help, she found that the plans included two separate tray-assembly lines — a complete extravagance for a hospital of its size. By revising the plans, eliminating the extra line and revising the specifications, she was able to effect a reduction of $75,000 in this hospital's equipment purchase.

As hospitals throughout the state developed confidence in the food service specialist consultant, it was found that they were making increasing use of her experience to double-check plans even when no apparent problems existed. Most satisfying to the consultant, personally, however, were those hospitals where she was involved from the outset in planning because she could make a far greater contribution by continuing collaboration with hospital and the architect, by specifying equipment and checking the installation, and, finally, in meeting the inevitable problems of conversion to the new facility. Anyone who has ever built a home can fully appreciate the fact that construction makes continuing demands upon the decision-making powers of the owner no matter how sound the initial planning or how qualified the architect.

Here are some special considerations that have been highlighted by the experience of the Connecticut consultant:

1. Determination of a satisfactory food distribution system is basic. Rapid improvements in food distribution systems are being made, hence selection by the hospital administrator and the dietitian of a proper service for their needs is an essential first step before plans are drawn. Interest today tends to favor the "hot and cold cart" as a system that allows optimum food quality at the proper temperature, maximum dietetic control, and minimum disturbance of patient floors. Poor space allowances in the kitchen that make loading these conveyors difficult, rough floors to cause spillage within the carts, inadequate elevators to transport them vertically, and other design problems, however, can destroy the values of such a system. Conveyor belts for vertically oriented hospitals offer special advantages and, for highly decentralized hospitals, the tradi-

tional bulk food cart may still be the best solution. It should be clear, however, that all these factors must be fully considered before the hospital commits itself to a new kitchen design or expensive equipment purchases, because the food distribution system must be coordinated with the operation of the hospital as a whole.

2. Effective personnel utilization results from careful analysis of every operation in the food service department. Labor hour studies frequently indicate that workers performing routine operations that machines could do are more expensive than the machinery to replace them. When materials and tools are readily accessible, fewer man-hours are required to accomplish the task.

Traditionally, hospital dietary departments have not made as much use of wheels, power and gravity as is possible to avoid lifting, carrying and double handling between operations.

Man-hour studies may well influence the decision concerning location of the kitchen in relation to the storage facilities and patient areas when relocation of the food service department is under consideration.

3. Collection of information on equipment for comparative purposes is essential. Visits to equipment manufacturers and hospital food service operations to gather data concerning efficiency of operation, availability and cost of equipment is time consuming.

The food service specialist accumulates available data and keeps it current in order to assist dietitians and administrators in their equipment selections.

Scrapbooks or folders concerning expensive equipment, such as dishwashing machines, mixers, food conveyors, and so on also aid in the preparation of detailed specifications. Careful specifications are an aid to competitive bidding.

Three basic criteria in dietary design, confirmed from the Connecticut experience, are: (1) The plans must be based upon a food distribution system that best meets the needs of the particular hospital; (2) personnel utilization must be studied to ensure long-range economy and efficiency of the new facility, and (3) comparative studies of equipment to fit the distribution system and layout should be undertaken objectively and full advantage should be taken of competitive purchasing. ■

Note exclusive new screw caps—ready now on several Heinz favorites!

Heinz Baby Foods for soft or bland diets so simple to serve . . . over 100 varieties!

Over 100 tempting kinds of Heinz Baby Foods add variety to *special-diet* menus. Economical and easy to serve, too. You reduce costs because there's no special cooking or processing. Just heat and serve. Each jar holds one portion. There's no waste.

- **Laboratory tests** prove Heinz Baby Foods contain less crude fiber than other strained foods. Thus, they're better suited for special diets. So order *Heinz* Baby Foods next time your salesman calls.

- **As a special service** to your patients, we'll send you *free* take-home copies of Heinz "Recipe Treasures" for soft and bland-type diets. Lots of exciting menu ideas for special-diet soups, beverages, main dishes, vegetables, salads, dressings, sauces and desserts.

- **These welcome menu ideas** are all so good . . . so easy to make with Heinz Baby Foods . . . and will assure diet uniformity at home for discharged patients. *Mail coupon today!*

Over 100 Better-Tasting Strained and Junior

HEINZ Baby Foods 57

. . . including meats, cereals and juices

MH-118

H. J. Heinz Co., P. O. Box 57, Pittsburgh 30, Pa.

Please send me _____ free copies of "Recipe Treasures" (for soft and bland-type diets).

Name _____

Position _____

Business Address _____

City _____ Zone _____ State _____

For additional information, use postcard facing Cover 3.

Menus for December 1958

Kathryn F. Jones
Food Service Director
Ventura General Hospital, Ventura, Calif.

1 Orange Juice Omelet • Roast Veal, Dressing Buttered Rice Minted Carrots Endive Salad Chilled Fruit Cup • Bouillon Grilled Ham Corn Fritters and Sirup Mexican Salad Apple Crisp	**2** Grapefruit Segments Soft-Cooked Egg • Grilled Lamb Chops Stuffed Baked Potato Buttered Asparagus Pineapple Salad Angel Cake • Fresh Vegetable Soup Hot Turkey Sandwich Buttered Peas and Celery Shredded Lettuce With 1000 Island Dressing Steamed Fig Pudding	**3** Blended Juice Bacon • Roast Beef, Gravy Mashed Potatoes Green Beans Sliced Tomato Salad With French Dressing Raspberry Ice Cream • Turkey Noodle Soup Spanish Pork Chop Baby Lima Beans Cottage Cheese Salad Orange Tapioca	**4** Grapefruit Juice Scrambled Egg • Chicken Fricassee Hot Biscuit Buttered Broccoli Steamed Rice Fruit Salad Cookies • Puree Mongole Soup Beef Pattie Buttered Mixed Vegetables Tossed Salad, Russian Dressing Whole Apricots	**5** Citrus Sections Cinnamon Buns • Salmon Croquettes With Cheese Sauce Whole Kernel Corn Glazed Carrots Potato Salad Lemon Meringue Pie • Vegetable Soup Baked Macaroni and Cheese Buttered Peas Tomato Aspic Salad Black Bing Cherries	**6** Orange Juice Soft-Cooked Egg • Baked Corned Beef Hash Seven-Minute Cabbage Cornbread Square Asparagus and Hard-Cooked Egg Salad Fruit Gelatin, Custard Sauce • Cream of Potato Soup Roast Beef, Gravy Whipped Potatoes Peach With Cream Cheese Center Salad Bread Pudding, Lemon Sauce
7 Stewed Prunes French Toast, Sirup • Roast Leg of Lamb, Mint Jelly Potatoes au Gratin Peas and Carrots Pineapple and Cottage Cheese Salad Chocolate Chip Ice Cream • Egg Flower Soup Cold Sliced Veal Stewed Tomatoes Macaroni Salad Spice Cupcake	**8** Applesauce Scrambled Egg • Hamburger on Bun French Fried Potatoes Buttered Mixed Vegetables Jellied Fruit Salad Vanilla Pudding, Apricot Sauce • Split Pea Soup Turkey a la King Buttered Asparagus Endive Salad With Oil and Vinegar Dressing Bran Muffins Pineapple Tidbits	**9** Apricot Nectar Bacon Omelet • Baked Pork Chop Buttered Rice Spinach With Lemon Pickled Beet and Hard- Cooked Egg Salad Fresh Fruit • Tomato Rice Soup Italian Spaghetti With Cheese French Roll Green Beans Mexican Slaw Coconut Cupcake	**10** Orange Juice Soft-Cooked Egg • Roast Turkey With Dressing Giblet Gravy Candied Sweet Potato Green Peas Jellied Cranberry Salad Coffee Ice Cream • Chicken Broth and Noodles Ham Salad Sandwich Potato Sticks Carrot and Raisin Salad Baked Apple	**11** Grapefruit Sections Grilled Ham • Pot Roast, Vegetable Gravy Whipped Potatoes Italian Squash Shredded Lettuce With Roquefort Dressing Fruit Gelatin, Whipping Cream • Cream of Celery Soup Link Sausage Spoon Bread Glazed Carrots Fresh Fruit Salad Prune Whip	**12** Grape Juice Fried Egg • Filet of Sole, Tartare Sauce Creole Corn Brussels Sprouts Tomato and Lettuce Salad Pumpkin Pie • Clam Chowder Tamale Pie Buttered Peas and Celery Deviled Egg Salad Nectarines
13 Pineapple Juice Pancakes, Sirup • Beef Vegetable Stew Hot Biscuit Buttered Asparagus Pear With Grated Cheese Salad Coffee Cake • Bouillon Barbecued Beef on Bun Harvard Beets Tossed Green Salad Floating Island	**14** Sliced Bananas Poached Egg on Toast • Roast Pork Loin Escalloped Potatoes Baby Lima Beans Spiced Peach Salad Butterscotch Sundae • Cream of Pea Soup Escalloped Turkey and Rice Sauteed Eggplant Grated Carrot and Pineapple Salad Oatmeal Cookies	**15** Prune Juice Muffins, Jelly • Breaded Veal Cutlet Broiled Tomato Half Parsley Potatoes Cranberry Orange Salad Tapioca Cream • Lentil Soup Chicken Salad on Bun Potato Chips Date and Apple Salad Peach Melba	**16** Stewed Apricots Scrambled Egg • Braised Beef Baked Yellow Squash Buttered Egg Noodles Cottage Cheese Salad Seedless Grapes • Cream of Corn Soup Individual Meat Loaf French Green Beans Potato Salad Jelly Roll	**17** Apple Juice Bacon • Grilled Liver With Bacon Baked Potato Vegetables en Casserole Spiced Beets on Lettuce Old Fashioned Rice Pudding • Beef Broth With Barley Dried Beef Omelet Buttered Asparagus Jellied Fruit Salad Crullers	**18** Orange Juice Soft-Cooked Egg • Baked Ham With Pineapple Sauce Candied Yams Buttered Peas Relish Plate Strawberry Ice Cream • Cream of Tomato Soup Open-Faced Sandwich Stuffed Baked Potato Frozen Fruit Salad Apple Betty
19 Apricot Juice Pancakes, Sirup • Halibut Steak Parsley Buttered Potato Stewed Tomatoes Apple, Cabbage and Raisin Salad Cherry Pie • Cream of Mushroom Soup Cold Plate: Salmon Salad, Sliced Tomatoes, Potato Chips, Half Hard-Cooked Egg Dutch Apple Cake	**20** Rhubarb Sausage Links • Hot Roast Beef Sandwich Fordhook Lima Beans Sauteed Okra Jellied Fruit Salad Lemon Cake Pudding • Vegetable Beef Soup Corned Beef Hash Pattie Creamed Cabbage Lettuce Wedge With French Dressing Cornbread Bartlett Pear	**21** Orange Half Scrambled Egg • Hamburger Pattie With Mushroom Sauce Diced Carrots and Celery Mashed Potatoes Salad Greens With 1000 Island Dressing Chocolate Pudding With Whipped Cream • Beef Noodle Soup Escalloped Ham and Potatoes Broiled Tomato Slices Grapefruit Salad Gingerbread With Orange Sauce	**22** Tomato Juice Bacon and Sweet Roll • Roast Lamb, Gravy Cubed Creamed Potatoes Shredded Beets Perfection Salad Cherry Vanilla Ice Cream • Cream of Corn Soup Cold Cuts Sliced Cheese Buttered Asparagus Assorted Relishes Brownies	**23** Steamed Prunes Soft-Cooked Egg • Baked Pork Chop Buttered Zucchini Potato Croquettes Banana and Peanut Salad Baked Custard • Broth Broiled Veal Pattie Brown Rice Sliced Orange and Coconut Salad Marble Cake	**24** Grapefruit Juice Grilled Ham • Meat Loaf, Tomato Sauce Lyonnaise Potatoes Broccoli Carrot and Raisin Salad Peach Cobbler • Bean Soup Hot Roast Beef Sandwich Swiss Chard Macaroni Salad Fresh Fruit Cup
25 Orange Juice Pancakes, Sirup • Tray Favor, Cider Roast Turkey, Dressing Giblet Gravy Cranberry Sauce Candied Yams Buttered Peas Poinsettia Salad Hot Mince Pie • Tray Favor Cream of Celery Soup Assorted Sandwich Plate With Jellied Fruit Center Holiday Cookies	**26** Kadota Figs Scrambled Egg • Seafood Plate, Cocktail Sauce Potato Chips Asparagus Tips Waldorf Salad Pumpkin Pie • Cream of Tomato Soup Macaroni a la King Buttered Carrots Spiced Crabapples Blueberry Muffins Rice Pudding	**27** Prune Juice Sweet Roll and Bacon • Baked Ham Potatoes au Gratin Hubbard Squash Health Salad Peanut Butter Cookies • Chicken Rice Soup Creamed Chipped Beef on Toast Buttered Beets Pineapple Cherry Salad Lemon Snow Pudding	**28** Fruit Compote Soft-Cooked Egg • Fried Chicken, Gravy Mashed Potatoes Green Beans Blushing Pear Salad Chocolate Ice Cream • Split Pea Soup Cheese Fondue Stewed Tomatoes Deviled Egg Salad Apricot Upsidedown Cake	**29** Sliced Bananas Pancakes, Sirup • Spaghetti and Meat Balls Garlic French Bread Buttered Asparagus Assorted Relishes Lemon Sherbet • Creamed Chicken Soup Veal Cutlet Chopped Spinach Sliced Orange Salad Devil's Food Cake	**30** Tomato Juice Fried Egg • Braised Sirloin Tips Baked Potato Escalloped Tomatoes Chef's Salad, French Dressing Pineapple Upsidedown Cake • Broth With Rice Cold Cuts Buttered Beets Fruit Salad Chocolate Pudding With Marshmallows
31 Prune Juice, Bacon • Chop Suey, Chinese Noodles, Buttered Peas, Tomato and Lettuce Salad, Mandarin Orange • Bouillon, Beef Roast, Potatoes au Gratin, Vegetable Aspic Salad, Assorted Cookies.					

Ready-to-eat or cooked cereal served on all breakfast menus.

FREE OFFER!

Post CEREALS

to prove that Instant Maxwell House is better for <u>your</u> operation than ground coffee!

The experience of successful users of Instant Maxwell House Hotel and Restaurant Coffee has proved that it is better than ground coffee for food service operations. Instant Maxwell House H&R Coffee was developed especially for the food service industry. We want you to try a free supply because we know you'll continue to serve it. And here are the reasons why:

- Instant Maxwell House has *uniformity of flavor*. Day in, day out, you can serve the same delicious cup of coffee!
- Instant Maxwell House offers *substantial economy*. Gives 10% greater yield. No coffee is wasted in grounds.
- Instant Maxwell House *can be made by anyone*—with your present equipment or in a special instant coffee machine, if you desire.
- Instant Maxwell House *saves labor*, eliminates 3 out of every 4 man-hours now spent in preparing ground coffee.
- And—Instant Maxwell House has proven consumer acceptance—it is *America's largest-selling coffee!*
- It is conveniently packaged in urn-size, glassmaker-size, and individual envelopes.

Yes, Instant Maxwell House is better for <u>your</u> operation than ground coffee—and you can prove it for yourself! Mail the coupon below for a FREE one-day trial supply of coffee and demonstration. There's no obligation to buy.

A Product of General Foods

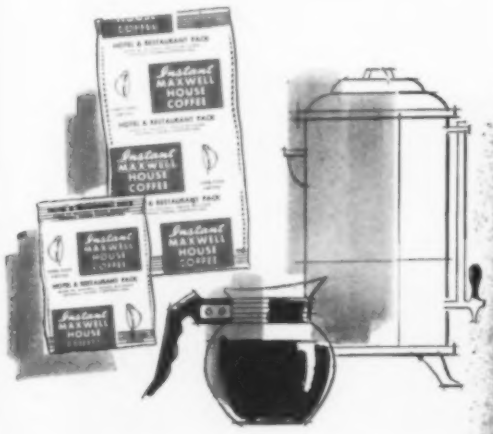
INSTANT SANKA COFFEE

Log Cabin Syrup

good seasons SOUP BASES AND SEASONINGS

MAXWELL HOUSE COFFEE

JELL-O DESSERTS



FREE OFFER

GF INSTITUTIONAL PRODUCTS DIVISION

GENERAL FOODS CORPORATION
INSTITUTIONAL PRODUCTS DIVISION
WHITE PLAINS, N. Y.

General Foods Corporation
Institutional Products Division
White Plains, New York

We're interested in a free one-day trial supply of Instant Maxwell House H&R Coffee and a demonstration. I understand we are under no obligation to buy.

Name.....Title.....

Organization.....

Address.....

City.....State.....

Equipment used (check one) ☐ Urn ☐ Glassmaker

Number Cups Served Per Day

OFFER EXPIRES MARCH 31, 1959 Dept. V

Piped Oxygen Pays in Safety and Savings

Piped oxygen in a new wing of this hospital proved so satisfactory in terms of safety, convenience and elimination of noise that the system was extended, and studies show it will pay for itself within three years

John Gettman

LIKE so many other hospitals in the United States, Memorial Hospital of Sandusky County at Fremont, Ohio, has had to expand drastically to meet postwar advances in population and greater use of hospital facilities. The original hospital, built in 1918, had a capacity of 79 beds. To keep pace with population growth of Sandusky County, now about 60,000 persons, a new wing was built in 1948 and a second wing in 1954. This last expansion provided not only more beds but also auxiliary services, including x-ray and physical therapy facilities, emergency rooms, pharmacy, central supply room, and laboratories.

Mr. Gettman is administrator of Memorial Hospital of Sandusky County, Fremont, Ohio.

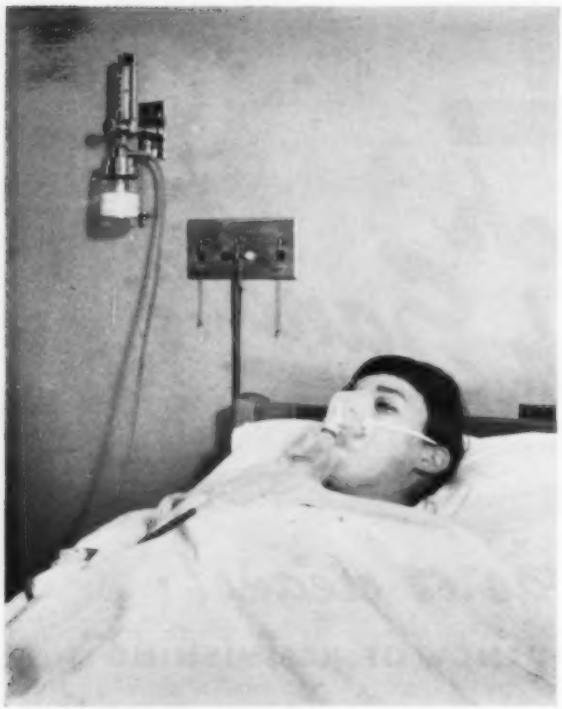
As we wanted completely modern facilities, and recognized the advantages of centralized oxygen distribution in hospitals, we installed a piped oxygen system in the second wing. Its value exceeded even our expectations.

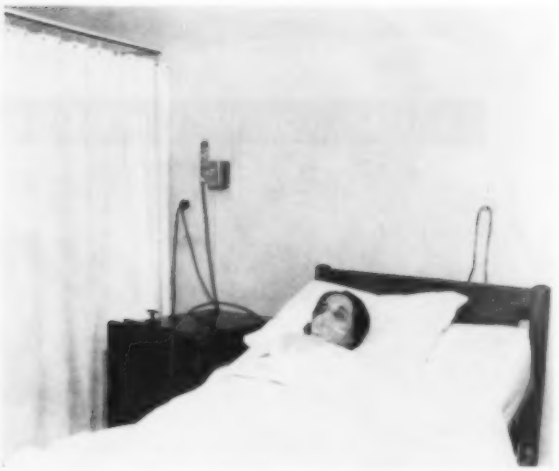
The piped system, besides finding favor and enthusiasm on the part of the nursing staff because it simplified its work, assured a constant oxygen supply where and when it was needed. It reduced to a few moments the delay from the time the doctor ordered oxygen for a patient and the beginning of therapy. Cylinders no longer had to be moved from storage to the patient's room, and all the confusion and noise in the corridors and the patient's room from doing so were eliminated. The piped system also eliminated the often critical period when the patient would be receiving no oxygen at all while an exhausted cylinder was being replaced.

From an administrative point of view, the advantages of centralized oxygen distribution that we valued included reduction of fire hazard and elimination of cylinder handling. While oxygen, of course, will not burn, it supports combustion. So the fewer the oxygen cylinders stored in the hospital, the safer we felt. With the piped system, the fire hazard is considerably less because the pipeline pressure is far lower than cylinder pressure and the volume content of oxygen in a piped system is only a small fraction

Zoning, or shut-off, valves in new wing of hospital are set into the walls flush with the surface. Location near nurse's desk would assure fast shut-off in an emergency.

Bulk supply system consists of 108 cylinders in three banks and control unit at one end. Control unit throws in reserve supply when the service supply is exhausted.





Above: Oxygen outlet stations in older section are mounted on the surface and piping is exposed. Although not as modern as concealed piping, it is not unsightly.

Left: Outlet station is provided in each patient room. Patient is receiving humidified oxygen by therapy mask from a flush type of outlet in the new wing of hospital.

of the volume usually stored in cylinders throughout a hospital.

Elimination of cylinder handling, besides reducing noise, avoids the possibility of injury to hospital personnel or damage to property from falling cylinders. Congestion on the hospital's service elevator is reduced, and less wear and tear on elevator, corridor and room floors from trucking and rolling cylinders eliminates continual repair and the special reinforcements that often are necessary at particularly heavily traveled areas such as elevator approaches.

We appreciated too the lower cost of oxygen distribution. Handling cylinders takes considerable time, particularly when empty cylinders must be moved by maintenance men from point of use to the storage area and full ones brought back. The cost of replacing cylinders in a hospital is estimated to run from 60 cents to $1 per cylinder. At nights and over weekends, when help is short, locating maintenance men to move cylinders may take considerable time and delay cylinder replacement.

The convenience and all the other advantages of piped oxygen induced us last year to consider the feasibility of piping the older portion of the hospital. A cost study convinced us that we should pipe the remainder of the hospital; in fact, we could not afford not to do so.

Without including the major cost of cylinder handling throughout the unpiped part of the building, the elimination of the residual oxygen loss, the cost of cylinder storage space, and replacement and repair costs for cylinder regulators, the cost study still indicated the economic advantage of total centralized distribution of oxygen. The study was based on actual cylinder oxygen cost *versus* that of bulk supply.

For an annual oxygen consumption of 480,000 cubic feet, calculations showed that using bulk oxygen would save us $1680. (This figure was based on the bulk-storage units being furnished and installed by the oxygen supplier.)

At an estimated cost for the installation of $50 per outlet, or $3500 for the 70 outlets necessary, potential sav-

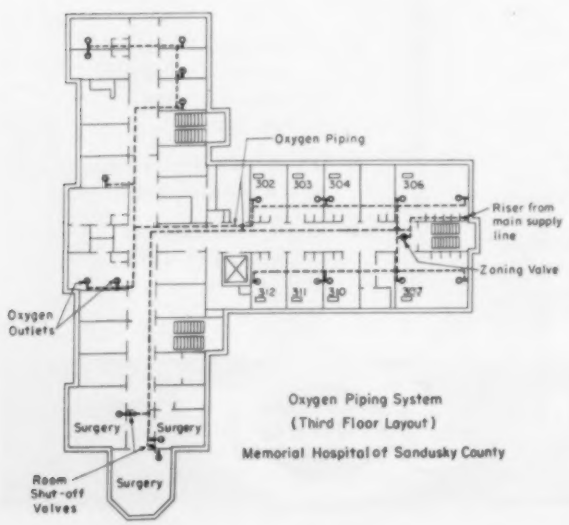
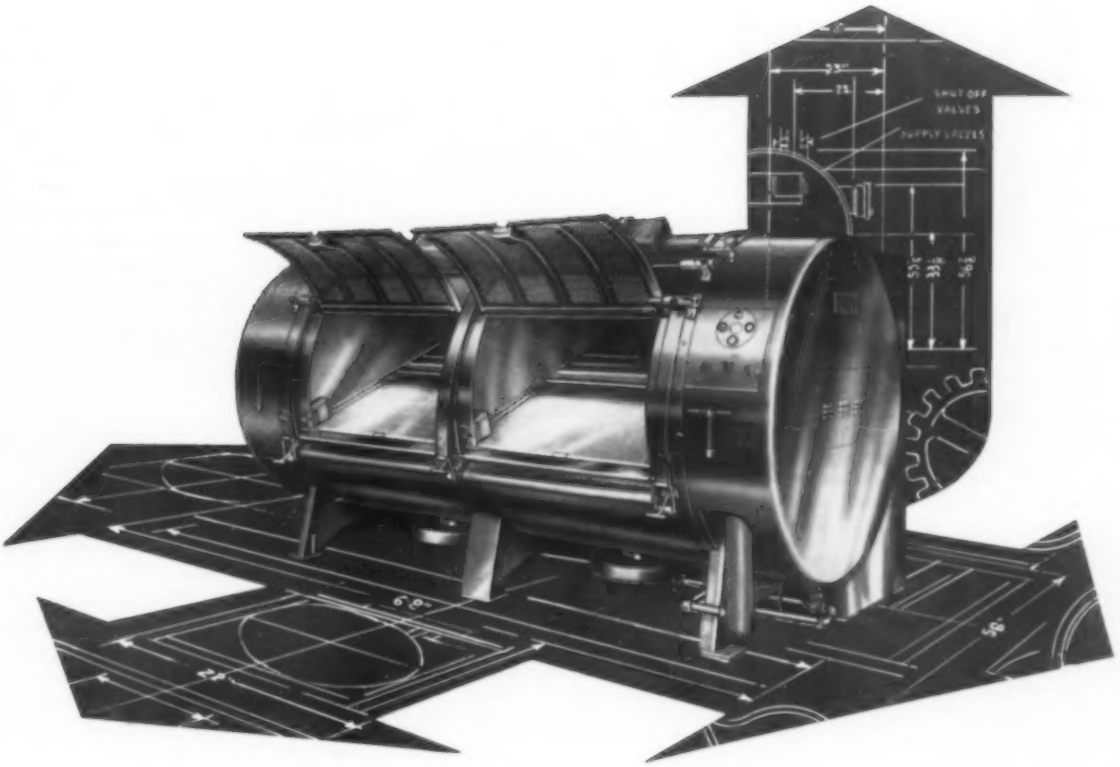


Diagram of oxygen piping system installed at Memorial Hospital, Fremont, Ohio. Oxygen outlets are located in all patient rooms as well as operating, recovery and anesthesia areas.



The hidden dimensions

IN LAUNDRY MACHINERY

Beyond the blueprints and floor plans, behind the specifications and cost figures, there are other important dimensions to be considered in the purchase of laundry machinery. These are in large part measures not of the machine, but of its manufacturer.

Troy, as the nation's oldest manufacturer of power laundry machinery, is proud of the way it has measured up in integrity and service during its 90-year history. The company holds an enviable reputation for truly objective surveys and equipment recommendations. In addition, Troy's nationwide sales and service representation with adequate stocks of genuine repair parts assures buyers of continuing satisfaction with the performance of Troy equipment. The company's program of pioneering research and development of new equipment is unsurpassed in the industry.

These are a few of the reasons why buyers can continue to look with confidence to Troy's complete line of quality laundry machinery.

Troy®
LAUNDRY MACHINERY DIVISION
American Machine and Metals, Inc.
EAST MOLINE, ILLINOIS

Barnstead Briefs

A COLUMN DEVOTED TO THE LATEST WATER PURIFICATION DEVELOPMENTS IN THE HOSPITAL

Your Water Still

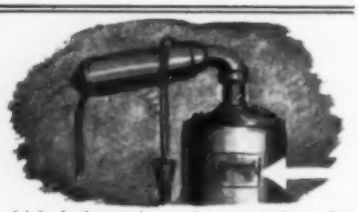
How much distilled water should your still produce . . . 5, 10, 15, 20, 30 or 50 gallons per hour? Consider what is *needed* for hospital expansion plus what is *required* for new central supply techniques. Larger still capacity *now* will save you money later. Barnstead builds *all* sizes: gas and electrically heated stills up to 10 g.p.h. . . . steam-heated stills up to 1000 g.p.h. Mayo Clinic in Rochester uses a Barnstead 50 g.p.h. steam-heated still, while the University of Michigan Hospital uses 75 and 100 g.p.h. Barnstead Stills.

Keeping Distilled Water Pure

Airborne contamination is pure water's greatest enemy. Freshly distilled water is like a vacuum, attracting not only acid and alkali gases; but dust, bacteria, and sub-micron particles of all kinds. The new "Ventgard," now on all Barnstead hospital-type distilled water storage tanks, is an air purifying device which removes these impurities from the air before air can contact the stored distilled water. The "Ventgard" can easily be installed in the field on existing tanks.

Operating and Maintenance Hints

Every Barnstead Still has matching operating and maintenance instructions. If your maintenance department does not have these instructions, drop us a letter including the serial number of your still



which is located on the nameplate. Instructions will be sent immediately.

Field Reports

How well a Barnstead Still removes pyrogens was demonstrated once again in a recent pyrogen test by Foster D. Snell Laboratories. A test solution was made up with pyrogen content far higher than would ordinarily be encountered. After passing through a single distillation by a type "Q" Barnstead Still, there was no trace of pyrogenic reactions in the standard rabbit test prescribed by U.S.P.

Would You Believe

Glass is more susceptible to the corrosive effects of distilled water than is tin. In a recent experiment 1,000 ml. of distilled water were evaporated down to 100 ml. The silica content rose from zero parts per million to ten parts per million. Similar test with tin container showed no increase in tin or other impurities. Most manufacturers of glass-lined tanks do not recommend the use of their equipment with distilled water where silica contamination is a factor.

New Products

"The Still You Never Need to Clean" is now a reality. The Barnstead Condensate Feedback Purifier in addition produces extremely pure distilled water. This unit provides for the condensation of boiler steam which is then passed through a de-

mineralizer, through a carbon filtration unit and then is introduced into the evaporator of the still. Final distillation removes traces of bacteria, organic matter, etc. Write for Bulletin #145 to: Barnstead Still & Sterilizer Co., 31 Lanesville Terrace, Boston 31, Mass.

ings in oxygen cost indicated that the piping system would pay for itself in slightly more than two years. While the final installed cost was somewhat higher than the estimated cost, the system will be paid for by savings in oxygen cost in only three years, and possibly less because of the expanded use of the readily available oxygen.

The bulk storage installation, in the rear of the hospital and adjacent to the street, consists of three banks of 36 cylinders each and a control unit. From there, oxygen is piped through an underground tunnel to the hospital building.

In the new wing, all piping is concealed in ceilings and walls. Outlets and zoning-valve boxes are set flush with wall surfaces.

In the older part of the hospital, however, piping is exposed, running along the ceilings of corridors and down the walls to outlets. Both outlets and zoning-valve boxes are surface-mounted. Though they are not so neat as flush-set boxes, their appearance is certainly not objectionable. A modernization program now under way in this section of the hospital will provide new dropped ceilings in the corridors. The new ceilings will hide the oxygen piping and improve the lighting arrangements.

Oxygen outlets are now located in all patients' rooms as well as operating and recovery rooms, nurseries and anesthetizing locations. Each outlet is equipped with an automatic shut-off valve.

As a safety feature, zoning valves are installed in risers supplied from the main oxygen supply line and in branch lines leading to patient outlet stations. In case of emergency, these valves shut off oxygen supply to the area affected without disturbing the supply to the remainder of the system. A shut-off valve also is located outside each anesthetizing location so that the oxygen supply can be shut off from outside the room if necessary. (See plan on Page 144.)

Since the oxygen piping installation has been completed, such complete satisfaction has been expressed by medical, nursing and maintenance personnel that the administration is convinced of this: Even if installing piping in the older part of the hospital had not been economically attractive, we would still strongly advocate a complete piping system because its convenience and other advantages so outweigh all other considerations. ■

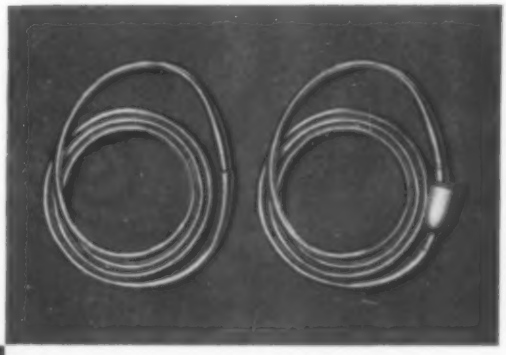
When You Order
Plastic Catheters or
Surgical Tubes **remember...**

DAVOL OFFERS A STYLE AND SIZE FOR EVERY HOSPITAL NEED

4 DRAIN TUBES—FOR OPEN OR CLOSED SYSTEMS

For Open System—Davol Urine Drain Tube. 3/16 or 9/32 I.D. Tubing ends are sealed—to place in use simply twist tube ends apart. Catheter connector is an integral part of tube itself—is easy to assemble and gives tight, secure fit.

For Closed System—Davol Urine Drain Tube with Adapter Cap. 3/16 or 9/32 I.D. Tube with latex adapter to fit over neck of drainage bottle for closed system. Caps have vent holes to prevent vacuum and insure constant fluid flow.



OXYGEN AND SUCTION TUBES with Funnel or Connector Ends

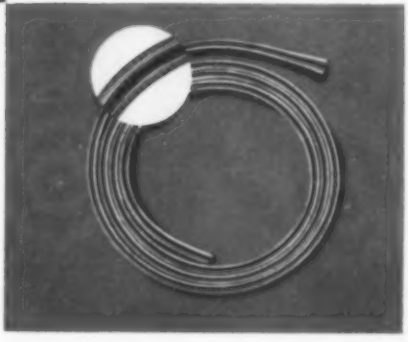
Assembled either with Nylon Connectors or the new Davol design with full-flared funnel, that eliminates need for extra Connectors.

LEVIN TUBES—TRANSPARENT OR X-RAY OPAQUE

Davol Levin Tubes are available in three styles—

1. Transparent with X-ray Opaque Line (as illustrated).
2. Transparent.
3. White X-ray Opaque, not Transparent.

All Levin Tubes with markings 18", 22", 26", 30" from distal end—smoothly bevelled eyes to minimize trauma. Inside surfaces are satin smooth.



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Color Therapy Is Applied With the Paint

Colors used in various areas of this state hospital are just what the doctors order to build patient morale, thanks to a functional system of paints that combines a wide range of colors with low paint inventory

B. E. Jones, Ph.D., and O. D. D. Ewing

SUPPLYING paint and scheduling its application are problems common to the engineering, housekeeping and nursing departments of all institutions. At the Winfield State Hospital and Training Center, Winfield, Kan., we are confronted by such problems involving 60 buildings of all types — frame, masonry and steel construction; interiors of plaster, wood, plaster board and composition board. We believe that we have solved many of our problems and that our system may be helpful to other hospitals.

In mental hospitals especially, the painting program is a large item. Maintenance costs and labor can be held to a minimum by the use of the best quality materials. In choosing paint, one must consider coverage, washability, toxicity and fire-resistant qualities.

Then there is the problem of color. In our hospital, a request to the psychology department about the colors to be used for wards, dayrooms and playrooms will always bring a variety of color prescriptions. If appropriate colors, helpful to the patients, can be chosen in advance the paint inventory can be held down. Cheerful or tranquilizing colors can be made quickly and economically to suit any need, regardless of location.

In our attempts to assist in the ward management of mentally retarded patients by means of environmental color we made several assumptions. The first assumption was that various environmental colors will affect the behavior of mentally retarded patients to a small but significant degree. If we can safely generalize from the objective results obtained by the use of color in industrial and commercial applications, this first assumption seems allowable. The second assumption was that the reaction of mentally retarded patients to various colors was essentially the same as that of normal persons. This second assumption seemed justifiable to us, though certainly it is only an assumption.

Observed Ward Conditions

Having made the two assumptions, our next step was to learn what were the conditions and needs on the various wards that might be affected by color changes. This process involved close observation of ward conditions and functions as well as discussions with nursing personnel to determine what aspects of the patients' behavior needed changing and what aspects should be unchanged. During this step it became apparent that many of the more direct and forceful methods we had hoped to use would have to be heavily compromised because of many limiting practical factors. An example or two will serve to indicate both our general approach and some of the limiting factors that were encountered.

One of the wards involved housed young mentally deficient children. These children spent a large part of their day in a dayroom where they played. Through observation, inquiry and general knowledge of the children's conditions we knew that while some of the children were normally active, playing in groups or with toys, many others were inactive — some even withdrawn and lethargic. The nursing personnel attempted to engage and stimulate the less active children but these efforts were limited by shortage of personnel and other demands on their time.

Under those circumstances it was decided to use environmental color as an aid in stimulating the children. At the time we made our study the walls of the dayroom were painted with a soft pastel green. We decided to change this to a warmer, more stimulating color. At this point we encountered a problem: The dayroom was not air conditioned, and had windows on the east, south and west sides, exposing it to the hot summer sun. This obstacle forced us to abandon the use of extremely stimulating colors since they would result in an apparent increase in the discomfort caused by high environmental temperatures.

Another factor which forced further compromise was that the children were likely to mark and scratch on the lower walls with toys, broken objects, and feces. We decided that the lower part of the walls should be painted with a color that would minimize the unattractive appearance resulting from the abuse to the walls.

Finally, then, weighing our interest in using highly stimulating colors against the problem of high environmental temperature and the need for maintaining a reasonably neat appearance of the lower walls, we prescribed a teal blue shade for the lower walls and a peach color for the upper walls. On another ward, housing severely

Dr. Jones is chief clinical psychologist and Mr. Ewing is maintenance engineer at Winfield State Hospital and Training Center, Winfield, Kan.

retarded adults, many of the patients were found to be using the restroom for sleeping during the day. Because patients on this ward were able to care for themselves at the toilet the restroom was made accessible from the dayroom so that nursing personnel would not have to lock and unlock doors each time a patient used the restroom. Patients sought the restroom as a refuge since it was relatively dark, cool and quiet, compared with the dayroom. To help alleviate this situation we prescribed that the walls of the restroom be painted a bright red. An increase in the intensity of light in the restroom probably also would have been of value.

Since we realized that we were increasing the high tension under which the nursing staff members usually worked by the extensive use of stimulating colors, we felt obliged to consider their needs, too. On the wards that were involved, the nurses have a small office in which they keep medicines and do charting. This room was painted a cool, restful blue-green on the premise that they needed some occasional refuge from the bright colors and frustrations of the ward. One must bear in mind, however, that in situations where the nurses and aides are not required to spend most of their time on the wards, the use of such colors in their office may encourage them to spend an inordinate amount of time in their office because of its relatively restful attractiveness.

These are examples of the many situations in which we thought that application of the psychology of color would be useful, and of the problems encountered in that application. These were not controlled studies. Subjective evaluations, however, have led us to think that some of our efforts were successful. We plan to make controlled studies the next time we paint the interior of our patient buildings.

In the past, paints were purchased as needed according to color and use. If a certain color was wanted, it was obtained either by mixing it in the paint shop from bulk colors or by ordering it in ready mixed colors. As a result of this system, an overestimate was usually made to be sure enough paint was ordered to complete a job. This meant that the remainder of the particular paint had to be stored until a specific use for it could be found.

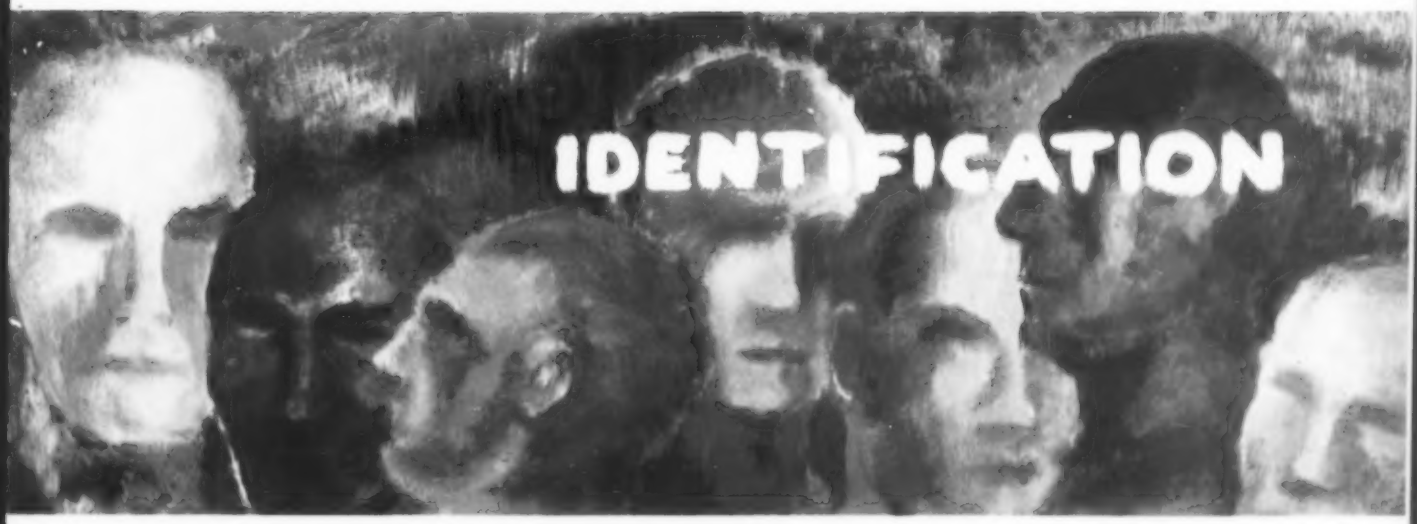
Our institution has eliminated this accumulation of excess paint. We now underestimate our needs for each job, then mix the additional quantities we need.

The system we use also holds our inventory to a practical working minimum. We are able to keep accurate records of costs, the colors used in specific places, and materials pertaining to paint and painting equipment.

We buy only nontoxic paint products, so we can paint at any time without evacuating patients. Other necessary considerations are fire-retardant qualities, washability and paints that will retain considerable film depth. Cheap paints are expensive, because the film washes away quickly. The paints we purchase retain up to 97 per cent of the film after 500 strokes. We do not use water-soluble or water-base paints.

With our system of harmonizing color charts, 1322 different colors are possible, ranging from whites to deep tones. All mixing of colors is done in our own shop, and can be done by anyone even though he may not be a painter.

The colorant used depends on the code or guide number in the selection chart. Colorants come in tubes of five



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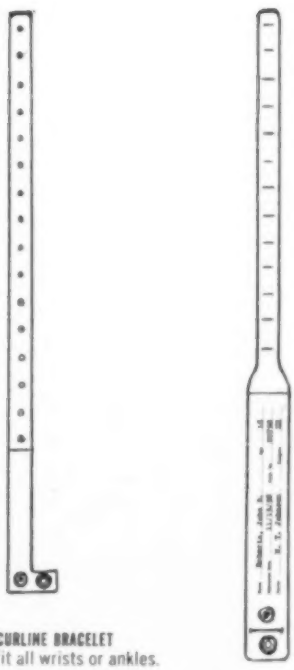

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sizes, each individually packaged. The size of the tube used depends on the quantity of paint to be colored. A minimum of six tubes per color in each size desired is recommended for a starting stock of color. There is a total of 17 colors. Cost of tubes ranges from 11 cents to 38 cents each. These tubes are filed in a cabinet for ready use and quick inventory.

A word of caution should be added: There are many color systems on the market, but few are in the category described here. Be sure to purchase only what is known as a "universal system" – no other will produce so many colors.

The base paints to which the color is added are prepared to produce the colors shown on the selection charts. These bases should not be used without the compatible colorant.

Bases purchased from a manufacturer other than that of the color system can be used, although when such a mixture is used, it may not produce the true color one could expect if the bases designed for the color system were used.

In requisitioning paint products, the engineer or housekeeper must first know exactly what he wants. Specifications are many and varied. It is important to work up the exact specifications, then check the delivered product to see that it meets specifications.

Procedure for use of any of the bases or stains is simple and foolproof: To obtain any desired color one merely has to check the formula for the color selected, take from the stock of colorants the size and color tube called for, add to the correct base according to quantity and shake well. Thorough mixing is essential and is best done with a shaker. Quantities of as little as half a pint can be made with this system. It is possible to match a patch, even after the surrounding surface shows fade or wear.

Our records show the date of painting, location, color name, chart number, quality used, brand used, and any other necessary remarks concerning the particular application. Should the need arise to repair and repaint any damaged surface, we merely consult the record for the color and type of paint originally used. Enough paint is mixed with this formula to cover the repaired area – no more. Thus repainting an entire area, or leaving an ugly mismatched patch is avoided. There are no leftover batches of paint and any color can be duplicated. ■

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No matter what your cleaning needs are, there's a Clarke just right for you — floor maintainers and wet-dry vacuum cleaners in a range of job-fitted sizes as well as the Clarke-A-matic self-propelled maintainer in electric, gasoline, propane and battery powered models, for larger floor areas. Have your Clarke distributor show you.

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Principles Are More Important Than Money

(*Continued From Page 85*)

buying an article at $100 instead of $150 or, indeed, buying an article at $150 instead of $100 and having it last twice as long. Economy is very largely a matter of opinion, and certainly economy in the long run is not usually brought about by buying cheap. Still less is economy just simple nonspending of money which ought to be spent, although in government circles this is universally believed to be the case.

The related question of control of expenditure also has many aspects which can be stated only briefly here. It should not be assumed that control of expenditure exists for the sole purpose of ensuring economy and, indeed, those who often control financial procedures (the accountants) are not in a position to comment upon the economy or otherwise of expenditure made. Control of expenditure, *e.g.* by audit regulation and procedure, exists largely to eliminate or reduce possibilities of defalcation and to ensure conformity with regulations of government and national undertakings. Quite obviously, a certain amount of audit and control is necessary, and the prevention of loss and defalcation is a duty which must be undertaken by every organization controlling large sums of money. There is, however, no doubt that the importance of accountability, as such, has assumed dimensions out of all proportion to its true value, at least in England, though one suspects that the American attitude toward this matter is more rational and sensible.

Control for its own sake can rapidly become established, particularly where government money is concerned, and the application of this minute and detailed control to the hospital service in England is one of the few valid criticisms that can be leveled against that service. No one would deny that there must be proper accountability for government expenditure, but there should also be some regard to the cost of methods of control and to a comparison of that cost with the cost of losses which the controls are devised to prevent.

It should also be remembered that the administrative exigencies of hospital organization are essentially more important than the letter of detailed accountancy regulations and the conflict between these two concepts cannot always be denied. From an administrative point of view there is no doubt that the acceptance of a percentage of loss is, as in the case of waste, the right attitude, and to attempt to eliminate loss by more and more controls is expensive, unjustified and, in the event, unsuccessful. Many controls in British hospitals, notably inventories, laundry checking systems, and so on, do no more than identify losses, and in many cases the losses amount to less than the cost of control.

These, then, are certain financial aspects of administration. Finance may well be the lifeblood of any organization but it must be the servant and not the master of the administrator. Certainly in the hospital world there are higher issues and more important questions than financial ones, and the hospital or hospital service which can deal with its financial questions by good administrative methods while keeping those questions in perspective is infinitely to be preferred to the hospital or service which permits its entire administration to be dominated by financial procedures and accountability generally, thereby demonstrating its lack of administrative initiative. ■

Don't Underestimate Value of Salesmen

(*Continued From Page* 99)

a stranger in the front office, just like the patient, and it follows that his reception may be typical of that given to our patients. His forthright opinion concerning his reception may well be indicative of the success or failure of the hospital's admitting policies.

I do not contend that an administrator should suddenly adjust his schedule to permit a long conference with each salesman to determine his opinion of the hospital. Neither administrators nor salesmen have time to spend in this way. I do suggest that a reasonable amount of time might be spent occasionally with selected salesmen to obtain their opinions of various procedures. The word *selected* is the key to the success or failure of interviews of this type. Obviously, the experience of the individual, his length of service in the field, his general character, his intelligent understanding of the hospital business, and similar criteria should govern whether his opinion is sought and the weight it should be given. Many salesmen would hesitate to criticize; others might flatter in the hope of creating good will. A few will give sound opinions and it is this group whose ideas should be worth eliciting. A little extra time with the selected salesman may provide some excellent information.

Rules or procedures that create unnecessary delays for the salesmen should be avoided: Every reasonable effort should be made to see them promptly; no administrator or purchasing agent should keep a salesman waiting for a long period while he completes routine business. If it is impossible to see the salesman, he should be so informed and be given a definite appointment for a future interview, if he desires one. Some hospitals require a salesman to see the administrator prior to visiting other hospital personnel. If the administrator does the purchasing, this system is obviously acceptable; if, on the other hand, the administrator does little or no purchasing and this requirement is merely a formality to inflate the administrator's ego, it should not be continued.

Administrators expect certain courtesies from salesmen; it is an obvious corollary that similar courtesy should be extended to the salesmen. One of the major failures of many an executive is his inability to extend the respect to others that he expects others to extend to him, and hospital administrators might well make an evaluation of their own attitude toward salesmen with this principle in mind.

It is difficult to imagine the hospital world with no salesmen. Without them, obtaining supplies and equipment would become one of our most time consuming and costly procedures. We would need to be much better informed to know what and where to buy the many items needed to make our institutions function. In many instances we would have to spend hours in search of items we now purchase with a simple inquiry directed to one or two salesmen. Price comparisons, information on new items, product differences, instruction in the use of equipment, and similar problems, now easily solved, would become serious obstacles to efficient operation. In fact, the mechanical work — preparation of orders, search for catalog numbers, correspondence and mailing problems, figuring of prices, discounts and quantity price rates — would all mean more work, higher cost, and, quite possibly, less efficiency. How fortunate we are to have salesmen! ■

How does the public measure healthfulness?

When judging healthfulness or the sanitation of an area, the layman depends on his eyes and nose. Even if an area looks clean he will be suspicious if a noticeable "cover-up" odor is present. Strong chemicals used to smother institutional odors may only disturb a patient, annoy a visitor and probably make the work of your staff more difficult.

Modern cleaning and sanitation systems, such as those developed by Airkem, include a combination of interrelated products to comfort the patient, assure the visitor and make the cleaning task easier. Airkem "A-3," for example, penetrates and cleans out dirt where soap and scrubbing cannot. It effectively combats the dangers of cross infection, kills odors on the surfaces and in the air and leaves a clean, air-freshened effect. This unusual combination of properties results from a unique formulation. Airkem "A-3" combines a non-ionic, synthetic detergent, a quaternary ammonium sanitizer, an organic chelating agent and Airkem odor counteractants.

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Airkem systems are instrumental in maintaining a healthful, enjoyable environment in hospitals throughout the U.S.A. Perhaps your institution, too, can use this system of products to advantage. An Airkem representative is always available at your convenience to demonstrate how these unique products can assist you.

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This achievement is made possible by the unique solubility of TETREX (tetracycline phosphate complex), which permits *more* antibiotic to be incorporated in *less* volume of diluent. Clinical studies have shown that injections are well tolerated, with no more pain on injection than with previous, less concentrated formulations.

TETREX Intramuscular '250' can be reconstituted for injection by adding 1.6 cc. of sterile distilled water or normal saline, to make a total injection volume of 2.0 cc. When the entire 250 mg. are to be injected, and minimal volume is desired, as little as 1.0 cc. of diluent need be used. (Full instructions for administration and dosage for adults and children, accompany packaged vial.)

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TETREX (tetracycline phosphate complex) (tetracycline HCl activity)..... **250 mg.**

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INTRAMUSCULAR '250' WITH XYLOCAINE

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And Carpets in the Corridor

(*Continued From Page 97*)

cate their patients to "the floor with the carpet," if it is possible for this to be done.

Obviously much depends upon the type of carpet used. This particular product, an uncut pile, locked seam, 100 per cent wool variety in mixed tones, is resistant to footprints as well as to ordinary spots and stains. Serious stains or burns can easily be rectified by cutting out the damaged area and inserting another piece.

Naturally the question of maintenance must be considered. The hospital housekeeper has the answer to date. During the six months in which she has been keeping accurate records of the time spent in maintaining the floors to meet the hospital's standards, she finds that four and one-half hours weekly have been devoted to the carpeted sixth-floor surface. To maintain the vinyl-asbestos tile on the floor below of parallel dimensions has required 10 hours per week, and on a comparable size floor with asphalt tile surface 20 hours of maintenance per week have been necessary. As Mr. Bradley puts it — "This means about $1.25 per hour, if you want to translate it into cost per square yard." But again, the complete story must wait until more time has elapsed.

Having recovered from that first pleasurable sensation of treading softly without fear of slipping or sliding down a hospital corridor, the visitor becomes conscious of other equally unique devices to give the hospital a new look. The drinking fountain, ordinarily an eye-sore, is inset into an alcove treated with half-by-half ceramic tiles in random design in colors complementary to the wall tones. To protect the wall surface from dirty hands, the tile is wrapped around the corridor so that anyone leaning on the wall to drink will be resting on the tile. Treated in such manner the drinking fountain, in addition to its utilitarian assets, becomes a decorative feature as well.

Adding to the skillfully selected and combined colors that provide a lift to the corridor are reproductions of paintings scattered here and there, effectively spotlighted. A wide variety of subjects and styles chosen to appeal to all tastes causes patients and visitors alike to stop and admire. An additional incentive for the patient who is told to get up and walk long before he has any desire to do so is the treatment of the end walls. In one instance a decorative wallpaper does the trick; in another, paint in complementary color provides variety.

Single rooms, while small, convey an impression of space and brightness through the introduction of clear basic colors, with sufficient contrasts to avoid monotony. Recognizing the role played by the visitor in the patient's daily routine, also the ever-present need to promote better community relations, a few bed-living rooms have been included.

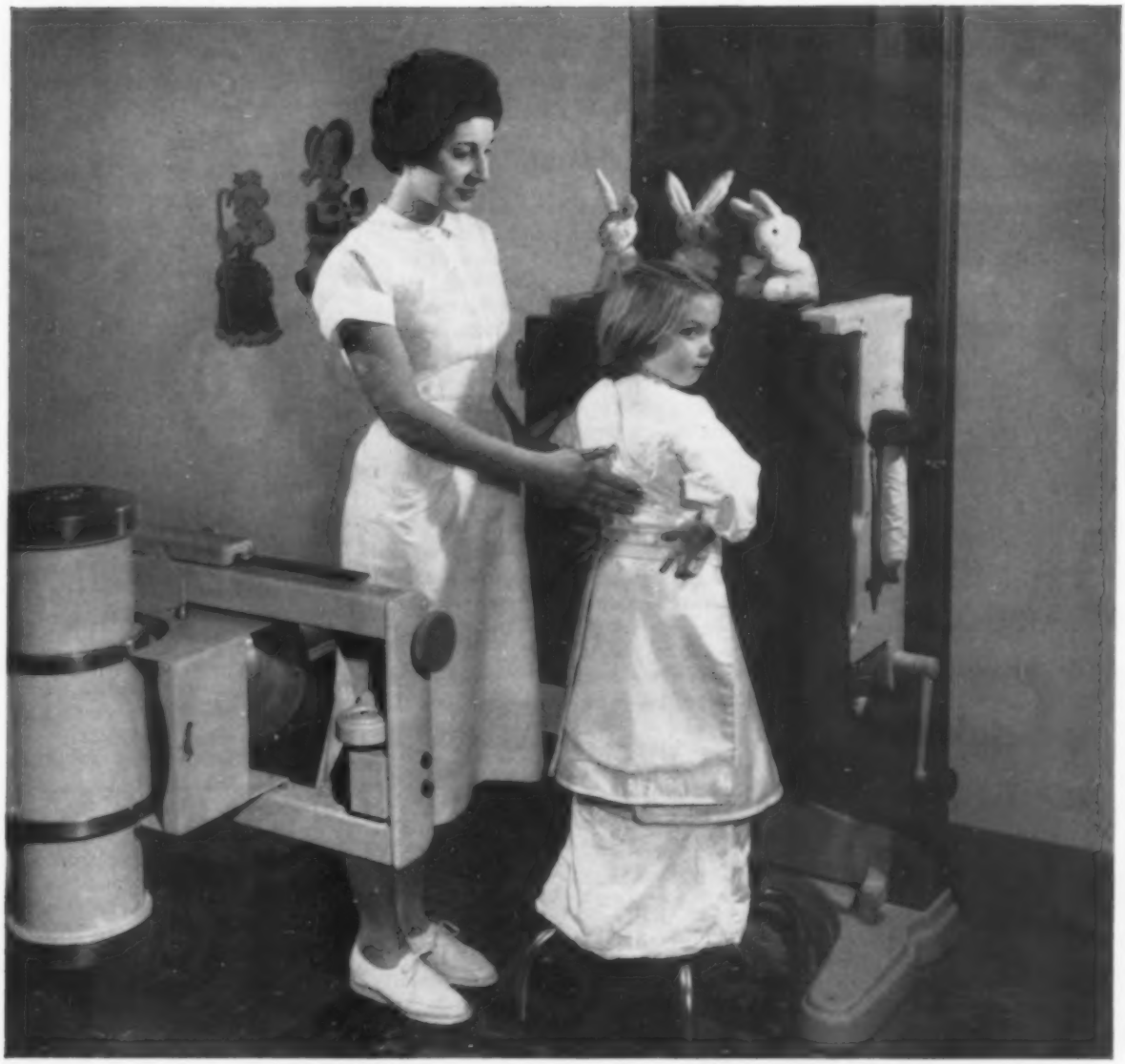
These, as the name implies, incorporate the two-in-one features of a social area and a professional area. Carpet in sculptured form covers one-half of the room as a background for a bed-sofa, a desk and an easy chair. The remaining area is devoted exclusively to the patient's professional requirements, with his bed, bedside and overbed table on a vinyl floor.

Such are the impressions of a hospital in new dress that the public carried away with it when Genesee held open house for its community several months ago. Since that time it has been the recipient of hundreds of calls from hospital representatives from other sections who have come to look and invariably to admire, also in some instances to question. For not everyone is willing to cast his lot unreservedly with the pioneer.

Their accomplishments to date in providing Genesee with a new look have not caused Mr. Bradley and his trustees to sit back in their harmonious surroundings and acknowledge with graceful "thanks" the compliments they are receiving. On the contrary, in true pioneering spirit, they continue to move forward.

Now in process is a long-term interior styling project which will embrace the older parts of the building, thus avoiding any unfavorable comparisons. Already the main entrance and adjoining lounge, smartly attired in club fashion in contrast to traditional hospital treatment, are adhering to the new pattern. Other areas are already in process.

That an over-all rehabilitation program can successfully be accomplished in time raises no doubt in the minds of those who are exerting true leadership in the hospital's affairs. Didn't Genesee's new look originate in the face-lifting process that transformed the old Victorian nurses' residence eight years ago? ■



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Surgeons Hear Reports on Antibiotic Use

(*Continued From Page 82*)

Congress, Dr. George J. Curry of the Hurley Hospital, Flint, Mich., reported the results of a five-year "efficiency study" evaluating the quality of transportation and handling of injured patients brought to the hospital's emergency department. Of 27,000 ambulance cases, only 70 infractions of good practice were reported among 60 ambulance attendants, he reported.

The American College of Surgeons Committee on Trauma will recommend that other hospital emergency departments keep such efficiency records to provide a constant check on the quality of transportation and handling of patients by ambulance attendants, Dr. Curry said. Attendants should have 20 to 30 hours of training before they are permitted to render emergency service; they should be re-examined annually and required to carry certification cards indicating proficiency, he suggested.

A survey conducted by the committee several years ago showed "fair to poor" quality of transportation of the injured in 28 out of 62 cities, Dr. Curry stated. "Tomorrow, you or I may require such service," he concluded. "We can only hope that the attendant who assembles and transports our battered frames will know that the ankle bone should be connected to the leg bone."

Menace of Speeding Ambulance

Dr. Curry said the speeding ambulance was a menace to the population and a threat, rather than a help, to the injured patient. "Speed is not necessary to save lives," he said. "An ambulance averaging 30 miles per hour travels five miles in 10 minutes. At 60 miles per hour only five minutes would be saved. In 2500 consecutive ambulance runs in Flint this time interval would not have influenced the course of a single injury."

In the 2500 ambulance runs studied, Dr. Curry added, haste was judged completely unnecessary in 98.2 per cent of the cases.

"In 1.8 per cent, expeditious handling was considered necessary, but a speeding ambulance could have increased the severity of the injuries," he pointed out. "The victim deserves a safe ride to the hospital."

Among more than 200 reports presented by surgical research teams, the following were of particular interest for hospitals:

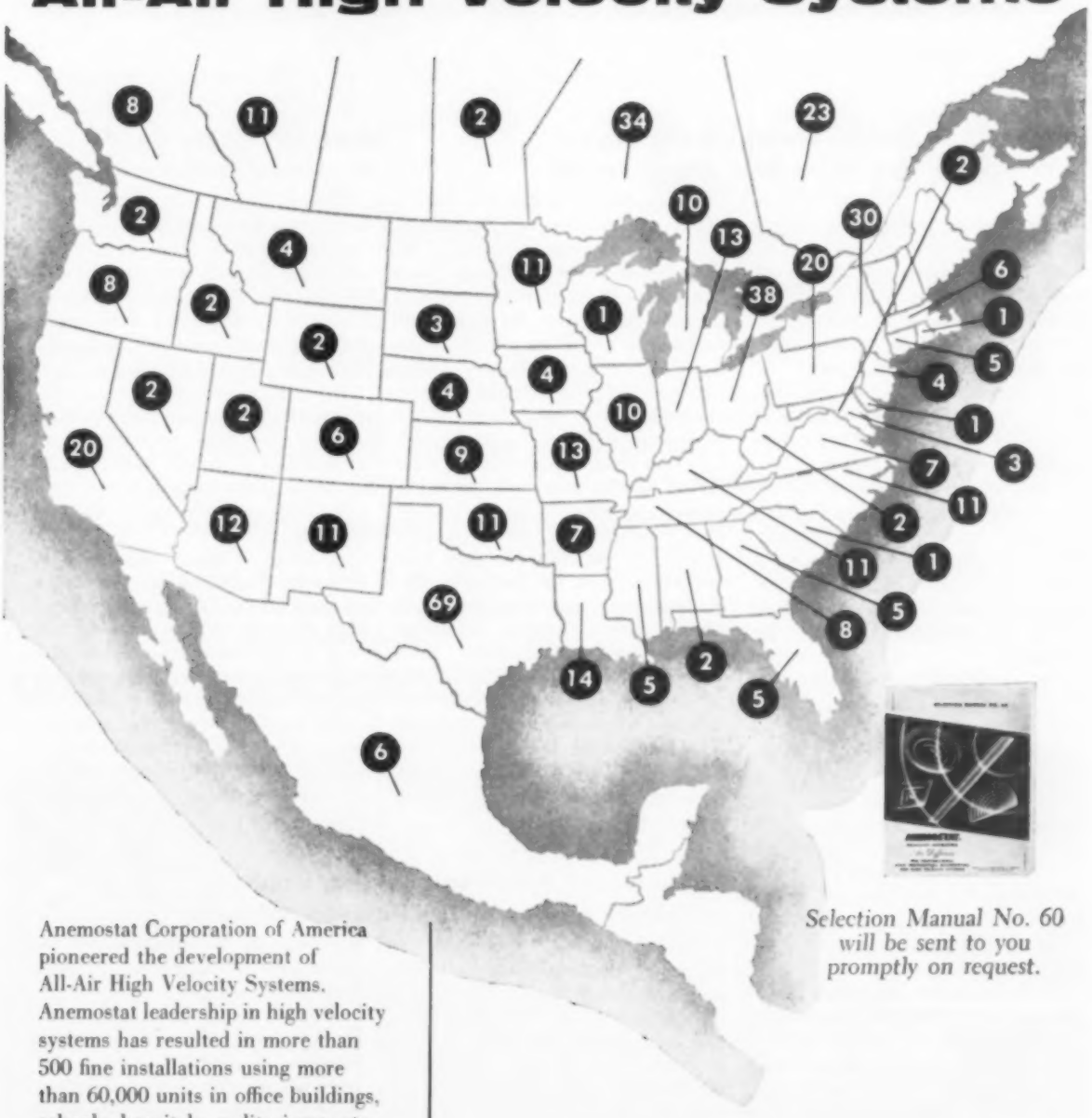
1. Reporting from the department of surgery at Vanderbilt School of Medicine, Nashville, Tenn., Dr. Sam E. Stephenson Jr. said that prolonged administration of oxygen-enriched air to animals during anesthesia brought instances of cardiac arrest in what appeared to be healthy hearts. As the concentration of oxygen administered was increased during the experiments, he reported, there was an elevation of carbon dioxide in the blood, along with instability of the electrocardiograms taken on the dogs. Dr. Stephenson described the results as "distressing, when one considers the degree of hyperventilation, excess oxygenation, and wanton changing of oxygen concentration that occurs during anesthesia for surgical procedures."

2. The practice of giving a large quantity of blood during and after major operations may cause disturbance in the fluid balance, Dr. Gunnar Thorsen, assistant professor of surgery, Karolinska Institute, Stockholm, Sweden, reported. "It often makes the patient listless, causes wet lungs, produces edema in the operative region and increases the number of postoperative complications," said Dr. Thorsen. He suggested that blood expanders should be administered for shock in the postoperative period for some patients who show little or no response to transfusions of blood and plasma. "I believe it is rational to maintain an adequate blood volume with Dextran as long as no more than ¾ liter of blood is lost," Dr. Thorsen added.

3. A small pump-oxygenator that can be functioning within 10 minutes and kept on a rolling table in constant readiness on the operating room floor was described by a group from the department of surgery at Tulane University School of Medicine, New Orleans. In another report, surgeons at Hahnemann Medical School and Hospital, Philadelphia, told of by-passing the heart for periods up to 90 minutes during surgery, but keeping the patient's own lungs functioning, in contrast to the usual heart-lung by-pass method used for heart surgery.

4. A chemical compound which is poured in liquid form into a fracture site to produce bonding of the bone ends was described by another Hahnemann Medical College surgeon. The plastic material used becomes an intimate part of the bone, Dr. Michael T. Mandarino reported. Results in the six cases in which the plastic "glue" was used were satisfactory, he said.

ANEMOSTAT reports on All-Air High Velocity Systems



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REPRESENTATIVES IN PRINCIPAL CITIES

NEWS DIGEST

Public Health Conference Recommends Staph Infection Controls . . . Wisconsin State and County Societies at Odds Over Blue Cross-Blue Shield Sales . . . United Funds Called Threat to Voluntary Agencies . . . Add "Why-How," Administrators Told

State Medical Society Warns County Group in Wisconsin Blue Cross-Blue Shield Fracas

MILWAUKEE. — The Milwaukee County Medical Society was warned last month to stop selling its Blue Shield plan outside the Milwaukee area in competition with the Blue Shield plan of the State Medical Society of Wisconsin, or face possible expulsion from the state society.

The action was taken by the state society's house of delegates at a special meeting at Stevens Point, Wis., September 28, following a year-long controversy which developed when the state society broke off a long standing agreement under which Wisconsin Blue Cross was selling the state society's Blue Shield plan outside the Milwaukee area, and the Milwaukee County society's plan in the Milwaukee area.

For the last several months, Blue Cross and Milwaukee County have been selling the Milwaukee plan all over the state, in competition with the state society.

Following a 55 to 22 vote in the House of Delegates, in favor of the resolution ordering the Milwaukee society to stop selling its plan throughout the state or risk expulsion, Dr. Jerome W. Fons of Milwaukee, state society president, resigned on the spot and left the meeting hall.

When delegates then approved a motion commending the state medical society secretary, Charles H. Crownhart, leader of the state faction in the Blue Cross-Blue Shield controversy, the entire Milwaukee delegation walked out, it was reported.

So-called "domination" or control of the practice of medicine by Blue Cross and hospitals has been a basic issue in the controversy, according to hospital observers. The state medical society view is that the Milwaukee County society is trying to dominate Wisconsin medicine, it said, and the state group fears Blue Cross and hospitals as "enemies of medicine."

A representative of the state medical society said the doctors had started Blue Shield to meet the threat of socialized medicine but that "today there is a greater threat of Blue Cross and hospitals taking over the practice of medicine. If the choice came between the government or hospitals taking over the practice of medicine, I'd take the government."

Milwaukee County delegates believe Blue Shield plans must cooperate with Blue Cross to give the public the greatest economy in health prepayment programs. The county medical society will withdraw its plan from competition with the statewide plan, provided the state society will again affiliate with Blue Cross, Milwaukee County representatives stated.

Wisconsin Blue Cross reported it has enrolled more than 75,000 new members who were formerly subscribers of Wisconsin Physicians Service, the statewide Blue Shield, since the state agreement with Blue Cross was discontinued.

Patients' Home Needs Explained to Nurses

ANN ARBOR, MICH. — Hospital patients must be taught to provide for their own nursing needs, so they can care for themselves after they are discharged to their homes, Theresa Phelps of the University of Michigan School of Nursing said at a meeting on nursing service here last month.

Patients not only need nursing services in the hospital but may also continue to need these services at home, Miss Phelps explained. "They should be taught in the hospital how to take care of themselves at home," she told the meeting.

A panel of former patients from University Hospital explained to the nurses the kinds of help they needed after discharge from the hospital, and head nurses demonstrated how hospital treatments can be carried out, using home equipment.

Dr. Anatol Rapoport, associate professor of psychiatry at the University medical center, explained some of the problems that arise in nurse-patient communications in the hospital.

Public Health Conference Studies Staph Problems, Makes Control Recommendations

ATLANTA. — There is no single way in which staphylococcal infections spread in a hospital, and there is no one method by which the spread of infection can be prevented, Dr. R. E. O. Williams of the Public Health Laboratory Service, London, England, stated here last month at a national conference on staphylococcal disease sponsored by the Public Health Service and the National Research Council.

"The roots of infection are numerous and probably often devious, and the precautions needed are many and complex," Dr. Williams stated.

Recent surveys in British hospitals indicate that approximately 5 per cent of clean surgical wounds and 10 to 15 per cent of newborn babies develop infections, Dr. Williams reported. Describing the record system in English hospitals, he said:

"It is our feeling that systems which simply require notification of cases of infection are less likely to give complete records than those that demand recording of the outcome, whether infection develops or not."

Outbreaks of infection in hospital nurseries began about 12 years ago in England, subsequently occurred in Canada, Australia and the U. S., and finally throughout the world, and were characterized in their early stages by conjunctivitis and impetigo, Dr. Thomas E. Shaffer, professor of pediatrics and preventive medicine at Ohio

(*Continued on Page* 166)

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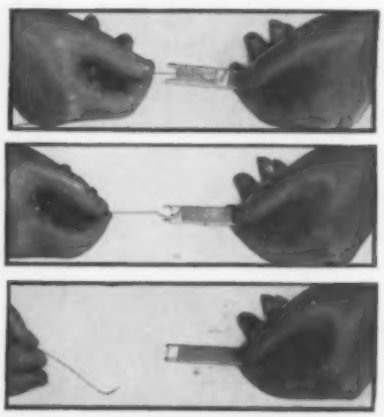

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(*Continued From Page* 164)
State University of Medicine, Columbus, told the conference.

"Failure to recognize these commonplace and seemingly unimportant lesions as forerunners of disastrous epidemics in which serious complications have occurred has allowed epidemics to progress before control measures were established," Dr. Shaffer stated.

Following three days of discussion, the conference recommended:

1. Organization of infection control committees in all hospitals, with authority to investigate infections and establish and enforce hospital policies.
2. Maintenance of an "infection log" in which all infections are classified and pertinent data recorded.
3. Exclusion from contact with patients of all personnel with boils or other active staphylococcal lesions and those identified as carriers of dangerous and epidemic bacterial strains.
4. Establishment of criteria for use of antibiotics in medical and surgical treatment; routine use of antibiotics to prevent infection deemed undesirable.
5. Arrangement for storage of cultures from staphylococcal infections, as an aid in tracing the sources of epidemics.
6. Isolation of infectious patients, especially those with pulmonary and skin infections.
7. Special precautions in newborn nurseries to eliminate overcrowding and maintain rigid sanitary standards.
8. Intensive and continuous training programs for professional and nonprofessional members of hospital staffs in infection problems.
9. Expanded laboratory service for identification of infectious organisms and research in the origin and spread of hospital infections.

More Two-Year Courses Urged for Nurses' Training

NEW YORK. — Expansion of nursing courses in two-year community or junior colleges was recommended here last month to help meet the growing shortage of room for freshman students in nursing schools.

Dr. Dominick F. Maurillo, regent of the University of the State of New York, predicted a shortage would be apparent in the next two years and would be more than four times as acute by 1970. He is head of a committee reviewing the state's supply of professional nurses.

In addition to suggesting that two-year colleges offer associate degree professional nursing programs, the committee recommended that other degree granting colleges and universities with four-year programs consider their roles not only in educating nurses but in training nurse educators.

"Wonder Drugs" Are Cited in TB Hospital Closing

WAUKESHA, WIS. — Speedier recoveries through the use of "wonder drugs" were named as the principal factor in the closing of the Veterans Administration tuberculosis hospital here October 1.

The 48 remaining patients were transferred to other V.A. hospitals. Chet W. Wadsworth, assistant manager, said the hospital originally had 210 beds and an average of 185 patients. He said the nationwide decline in the number of patients was due to the use of drugs which had reduced the average stay in hospitals for tuberculosis from 24 months to only eight months.

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A.M.A. Announces New Drug Identification System

CHICAGO. — A drug coding system, based on such characteristics as size, shape, color, scoring and similar features of tablets and capsules, has been announced by the American Medical Association.

The new process is the result of several months' study of 500 tablets and capsules by John J. Hefferren of the A.M.A. chemical laboratory.

Through its use it is possible to narrow down a drug's identity to a relatively few products in a short time, the *A.M.A. News* reports. Then chemical tests can be made to confirm the identity of the drug.

Under the new system, instead of making a chemical analysis, the investigator first notes all physical characteristics of the unknown drug by means of a reference chart. When he finds a given set of characteristics describing the drug, he makes chemical tests for final identification.

The A.M.A. hopes to publish a text listing about 5000 products. It will later be expanded to include more products and be kept up to date by supplements and new editions, the announcement stated.

Trustees' Institute Hears Panel of Hospital Leaders

PRINCETON, N.J. — A record number of 51 trustees, 33 administrators, 10 assistant administrators, and 17 other hospital employes attended an institute for hospital trustees held here September 24. A total of 37 hospitals was represented at the session, sponsored by the New Jersey Hospital Association.

Talks were given by Dr. Kenneth V. Babcock, director of the Joint Commission on the Accreditation of Hospitals, on the subject, "The Hospital Accreditation Program"; Raymond P. Sloan, chairman of the editorial board of The MODERN HOSPITAL, on "The Changing Role of Hospitals in the Community," and Dr. Kenneth E. Gardner, president of the Medical Society of New Jersey, on "The Relationship Between Trustee, Administrator and Physician."

The audience was divided into three discussion groups and each speaker spent one-half hour with each group, discussing in further detail his subject and answering questions. Speaker at the evening session was Dr. Basil C. MacLean, president of the Blue Cross Association.

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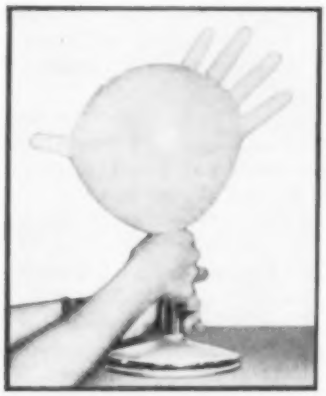

Press toe down on top of treadle and ¼-horsepower compressor inflates glove to desired size in matter of moments, spraying powder clear to fingertips at same time.

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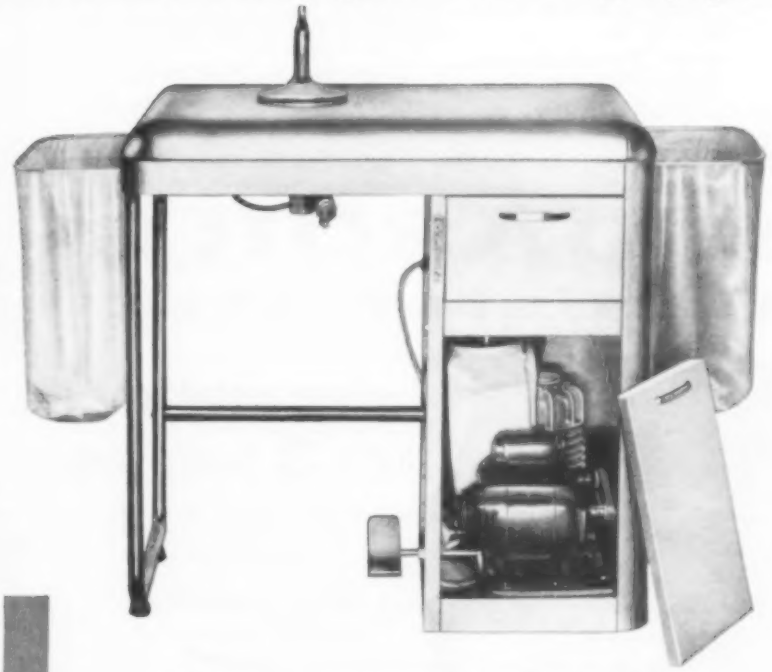

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Hospital Accountants Name Eight New Fellows

CHICAGO. — Eight new fellows have been named to the American Association of Hospital Accountants, Robert M. Shelton, president, announced.

New fellows are: Sister Mary Bertrand, C.S.C., controller, Holy Cross Hospital, Salt Lake City; G. DeWitt Brown, controller, Baptist Memorial Hospital, Jacksonville, Fla.; Sister Mary Gerald, C.S.C., general treasurer, Sisters of the Holy Cross, St. Mary's Convent, Notre Dame, Ind.; V. G. Edmondson, accounting specialist, Oklahoma Hospital Association, Tulsa; Sister Mary Leo, business manager, Mt. Carmel Mercy Hospital, Detroit; Gerald V. Hammons, business manager, Arkansas Baptist Hospital, Little Rock, Ark.; Ray Everett, assistant administrator, Roper Hospital, Charleston, S.C., and Sister M. Electa, business manager, Bethania Hospital, Wichita Falls, Tex.

High score paper on the examination was written by Sister Mary Bertrand, the association reported.

The fellowship roster now includes 27. Nineteen passed the test in 1957.

Corporate Contributions Lead in Hospital Drives

NEW YORK. — Corporate contributions accounted for the largest proportion of funds in 40 hospital campaigns studied by the American Association of Fund-Raising Counsel, the association reported. The median corporate contributions were 33.5 per cent of the total raised. They ranged from 71.7 per cent of the total in one campaign to 1 per cent in another.

The median of trustee contributions was 5.4 per cent of the total contributed. The highest percentage was 16.8 per cent and the lowest was 1.1 per cent, in the campaign which raised the largest sum.

Contributions of medical staffs ranged from a high of 37.5 per cent of the total contributed to 0.09 per cent. The median was 11.2 per cent.

In addition to the pattern of giving, the association reported that only 7 out of the 40 campaigns failed to reach their goals. They raised a total of $65,552,997 in all. The highest cost in any campaign reported was 9 per cent of the total raised and the lowest was 2 per cent. The median was 4.3 per cent.

Twenty-two drives required an average of 11 weeks for preparation and 35 had an average intensive period of 15 weeks. Professional staff numbered three on the average. An average of 837 workers were enlisted by 35 campaigns. The highest number in a single drive was 4400 and the lowest was 60. Number of prospective givers ranged from 19,450 to 300.

Describe New X-Ray Image Amplifier

CLEVELAND. — An "image amplifier" that furnishes a picture 350 times brighter than the ordinary fluorescent screen and exposes patients to only one-fifth the ordinary x-ray dosage was demonstrated here last month.

The new device can be used in the diagnosis of any condition where x-rays have been used previously, it was reported.

The image amplifier is an electronic "booster" or accelerator, by means of which the usual x-ray image is intensified and amplified electronically, it was explained. It is expected the amplifier may be especially useful in diagnostic study of heart disease, the manufacturers, Picker X-Ray Corporation of Cleveland and Zenith Radio Corporation of Chicago, announced.

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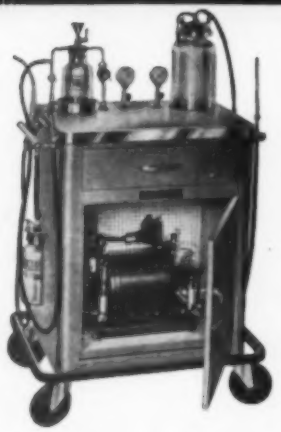
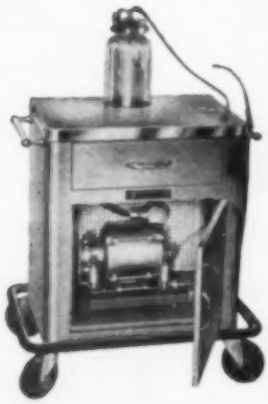


*Improved *motor assembly and simplified electrical installation result in lower manufacturing costs which are reflected favorably in the prices of these new models.*

These suction and anesthesia units are totally explosion proof and approved by Underwriters' Laboratories, Inc. for use in Class 1, Group C hazardous locations. All tubing, casters and bumpers on the Bellevue and Printz models are of conductive rubber. Motor units are rubber mounted, minimizing vibration. Cabinets are insulated with Celotex to insure noiseless operation.

NEW IMPROVED BELLEVUE MODEL, CAT. No. 100-75.

Now equipped with 32-ounce suction bottle for the exclusive use of the anesthetist in addition to the regular 1-gallon suction bottle and 32-ounce ether bottle.



NEW IMPROVED PRINTZ MODEL SUCTION UNIT, CAT. No. 100-80.

Equipped with 1-gallon suction bottle and recessed suction gauge. *Printz* Model, Cat. No. 100-85 (not illustrated) has a 32-ounce ether bottle in addition to the 1-gallon suction bottle.

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Steelworkers Ask Study of Union's Health Plan

ATLANTIC CITY. — A broad study of the United Steelworkers' health and welfare program was asked by the union at the close of its convention here last month. The group also discussed setting up union operated hospitals and clinics in areas where they are needed.

The union said it had met with some success in limiting the size of rate increases requested by existing health plans "but by no means are we completely satisfied with the reasons given for the skyrocketing costs of our hospitalization and medical care programs."

"We are confident that a united and determined membership can win the goal of full medical security for all steelworkers through the process of collective bargaining," the union statement said.

One union spokesman said a preliminary survey of needs had uncovered areas in which existing hospital facilities are insufficient to handle even the day-to-day load. In some areas, he said, facilities would be completely inadequate in event of disaster or epidemic.

The union hinted the money for the study would come from company funds already established for medical and hospital care plans.

Tiny Cardiac Monitor Has Many Uses, Doctor Says

CHICAGO. — A new type of cardiac monitor, weighing only 6 ounces, was described by Dr. William F. Veling, Detroit, in a recent issue of the *Journal of the American Medical Association*. The tiny device can be set on a surgical patient's arm and gives off a "beep" if his heart is functioning normally.

A self-contained unit powered by batteries, it needs no long, complicated electrical wiring and its audible "beep" overcomes the disadvantage of older machines, which need constant visual attention. "It enlists the attention of the entire operating room team, but frees their eyes and hands for other duties," Dr. Veling said.

Another possible use for the device is that of monitoring the hearts of critically ill patients, especially those with heart disease, he said. Because it is small, relatively inexpensive, and easily stored, a hospital could keep a number on hand for use in patients' rooms.

In conclusion, Dr. Veling said: "Small, reliable, rugged and easy to operate and maintain, a miniature cardiac monitor with its reassuring 'beep' could become as commonplace as the stethoscope in the surgery."

A.C.H.A. Gives Dinner in Honor of Canadian

TORONTO, ONT. — Arthur J. Swanson, chairman of the Ontario Hospital Service Commission, was honored October 27 at a testimonial dinner given by the Board of Regents of the American College of Hospital Administrators during the annual meeting of the Ontario Hospital Association.

More than a hundred fellows, members and nominees of the College from Canadian provinces attended.

Mr. Swanson was superintendent of Toronto Western Hospital from 1930 to 1956. He has been first vice president and a member of the board of trustees of the American Hospital Association, was president of the Ontario Hospital Association in 1937-38, and has been its executive secretary. He has been president of the Toronto and the Canadian Hospital associations.

Nurses' Salaries Rise, I.H.A. Survey Indicates

CHICAGO.—Average starting salary for registered nurses on general duty in Illinois hospitals has increased from $278 last year to $289 a month in 1958, the Illinois Hospital Association reported in its annual survey.

Since 1954, when the I.H.A. first began collecting these data, the average statewide starting rate for nurses has increased by 14 per cent. This year, for the first time, the work week for nurses dropped below 40 hours, the report showed. Taking into account this decrease in the work week, nurses' salaries increased by 23 per cent throughout the state, from $1.36 an hour in 1954 to $1.67 in 1958.

For the first time, too, the average "going" rate for general duty nurses (amount actually being paid in the classification) exceeded $300 a month. This year's statewide "going" average is $309 a month, compared to $297 a month last year.

Average starting salary for head nurses in Illinois is $323 a month and the "going" rate is $347. Thus, the report shows, the increment for advancing from general duty to head nurse is usually from $35 to $40 a month.

Licensed practical nurses had an average starting rate of $200, and a "going" rate of $219 a month. For nurse's aides, the starting rate is $159 a month, the "going" rate $179. The practical nurse starting salary increase over 1957 was a little more than 5 per cent, compared to the registered nurses' 4 per cent. Nurse's aides experienced only a nominal increase of less than 3 per cent in their starting wage, the report said. The aides also continued to work a slightly longer week.

"Going" rates increased for all "paramedicals" during the year. The relative position of each and the amount of increase were reported as follows: nurse anesthetist, $511, up $31; pharmacist, $489, up $27; nurse instructor (master's degree), $480, no data for 1957; psychiatric social worker, $452, no data for 1957; medical social worker, $444, no data for 1957.

Other rates were: dietitian, $423, up $31; physical therapist, $414, up $17; medical record librarian, $395, up $17; medical technologist, $389, up $18; occupational therapist, $388, up $20; x-ray technician, $364, up $14, and registered nurse (general duty), $309, up $12.

Physicians Asked To Help Blue Cross Save Millions

NEW YORK. — Cooperation with physicians could save the state Blue Cross about $23 million a year, students and faculty at Columbia University College of Physicians and Surgeons were told at opening exercises here recently.

Dr. Ray E. Trussell, professor of medicine at Columbia, reported: "If the average length of stay of Blue Cross patients in hospitals were reduced one-half day and if one in every 50 Blue Cross patients were kept out of the hospital through some other form of care, the saving in Blue Cross payments would be approximately $23 million a year in New York State.

"Since the length of stay and admission rates are a function of the physician's decision, the opportunity to render a public service is inescapably obvious," he added.

Dr. Trussell is directing a year-long study of the 19 nonprofit health insurance plans in the state. The study is being paid for by the plans.

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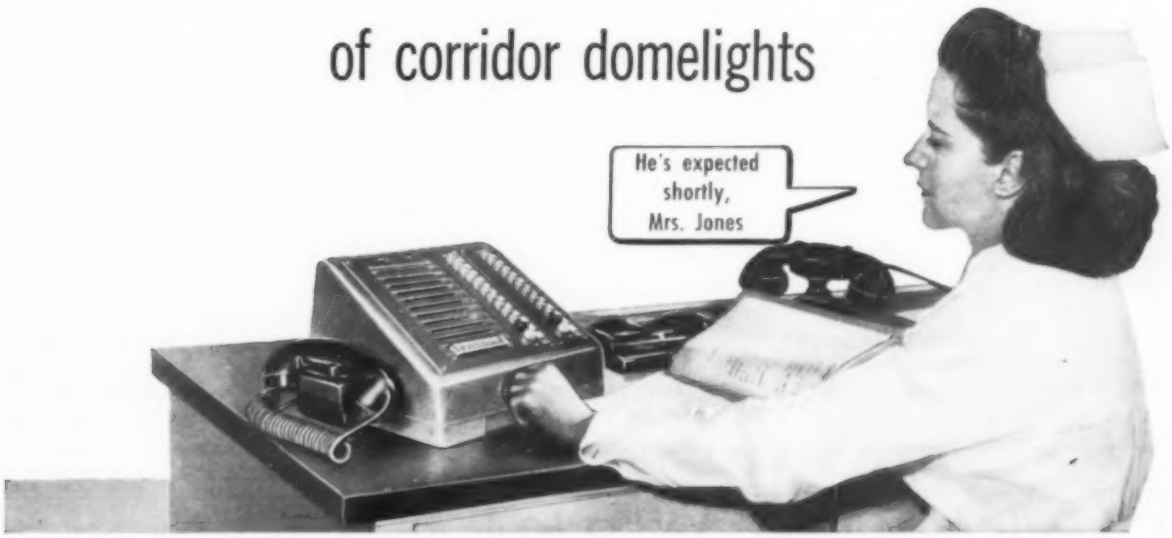

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Wage Increases Blamed for Higher Hospital Costs

CHICAGO. — General wage increases were cited as the primary factor in the rapid increase of hospital costs by Ray M. Amberg, president of the American Hospital Association.

In an *A.M.A. News* interview, Mr. Amberg said: "The chief element in increased hospital costs is the result of a general rise in wages. These wage increases have been for everybody — elevator man, cook, maintenance man, laboratory technician.

"At our hospital," he stated, "2.2 hospital employes are required for each patient. Since no one gets less than $10 a day, the personnel cost alone for each patient is at least $22." [Latest figures show that average hospital expense per patient day is $28.-81.]

Mr. Amberg pointed out that part of the rise in hospital costs has come from expensive equipment, such as heart-lung machines and cobalt bombardment sources, which were unheard of 20 years ago.

Many common illnesses that required hospitalization 20 years ago now are treated at home with "wonder drugs" or new technics; as a result, patients entering hospitals are those requiring more complex care, Mr. Amberg said. People expect and are receiving better and more personalized hospital care.

"We've bought longer and happier life with these costs. Thirty years ago the average patient stayed in the hospital 30 days at a cost of $125. Today, the average stay is seven or eight days at a cost of about $250. But the patient loses 50 per cent less time from work if he is a wage earner and consequently is better off financially," Mr. Amberg declared.

Administrators Urged To Add "Why-How"

WASHINGTON, D.C. — Hospital administrators need to add more "why-how" to their "know-how," Mrs. Lillian Gilbreth, work simplification expert and industry consultant, said.

"Why-how" — taking a new and open-minded look at why, how and by whom jobs are done — is the key with which better work systems can be devised, she told the semiannual Veterans Administration Institute for Hospital Administrators.

More attention to principles of work simplification, or organization and methods improvement, so profitably used in industry, can produce greater savings in time, effort and expenses of operating hospitals, Mrs. Gilbreth said.

These principles are applicable to small as well as large hospitals, she said, but the chief of an organization's work simplication program should be directly responsible to top management if he is to do his job effectively.

She said work simplification must be carried out within the framework of the organization's code of ethics and is an educational process for employes.

Mrs. Gilbreth also made a plea for plain language to help knowledge from experts in many fields filter through to management and to help management be understood by employes.

The increasing number of technical words in the language is a bar to this sort of communication, she said, but even more difficult than new technical words are the old ones that take on new meaning within particular groups.

Films or movies can be a valuable aid in devising and teaching work simplification, the consultant said, but the best films for this purpose for each organization are those made within the organization and showing its employes.

Don't Lower Wages To Cut Costs, Says Group

SAN FRANCISCO. — More efficient and intelligent use of personnel, and not lower wages for hospital workers, is the answer to rising hospital costs, according to a newsletter published here last month by the Martin E. Segal Company, labor health consultants.

By more imaginative planning and arrangement of hospital facilities, skilled personnel can be assigned to special areas of the hospital where their training and ability can be used to maximum advantage, the newsletter said.

"In the last 10 or 12 years hospital personnel has gained salary increases at very nearly twice the average rate for the rest of the work force," the bulletin stated. "These increases were necessary to compete for an adequate labor staff. Further wage rises will be necessary to continue to meet the competition. For hospitals, as for other employers, low salary rates may be expensive in terms of efficiency and productivity, and service.

"Hospitals need a high percentage of professional and technical employes, and they must pay to get and keep them," the newsletter said.

Other methods of cutting costs suggested by the company were:

1. Elimination of per diem nursing personnel and replacement with full-time nurses.
2. Analysis of quality control, portion control, and service in the dietary department.
3. Establishment of a formulary.
4. Inauguration of safety programs to reduce compensation and liability insurance rates.
5. Use of labor saving machines.
6. Group purchasing of certain items, such as milk, coffee, bread, fuel and supplies used in large quantities.
7. Modernization and rehabilitation of facilities for more efficient use.

Nursing Home Group Elects Florence Baltz

SAN FRANCISCO. — Florence Baltz of Washington, Ill., was named president of the American Nursing Home Association at its meeting here last month. Mrs. Baltz succeeded Ira O. Wallace of New Castle, Ky.

Dr. F. J. L. Blasingame, executive vice president of the American Medical Association, addressing a luncheon meeting, stressed the growing importance of nursing homes in the care of the aged and chronically ill and urged closer liaison between the nursing home administrators and hospitals. He and other speakers cited the great advances made in nursing home operation and standards in the last decade.

Other new officers elected at the meeting were: first vice president, Alton Barlow, Canton, N.Y.; secretary, Eldred Thomas, Dallas; treasurer, Morrill S. Ring, Medford, Mass., and historian, Honour Huffman, Logansport, Ind.

Hospital Council To Study Approaches to Financing

PITTSBURGH. — The Hospital Council of Western Pennsylvania will make a study to determine the best approach to coordinated planning for future hospital capital requirements in Allegheny County, Robert M. Sigmond, the Council's director, announced.

The study is expected to be completed by early 1959 and will include recommendations on the most effective form of community organization to carry out coordinated planning and financing of new hospital facilities, Mr. Sigmond said.

Two Pharmacy Groups Announce Election Results

WASHINGTON, D.C.—Dr. William Heller, director of pharmacy service, University of Arkansas Medical Center, Little Rock, has been elected president of the American Society of Hospital Pharmacists. He is also director of the American Hospital Formulary Service.

Other officers elected were: vice president, Vernon Trygstad, chief, pharmacy branch, Veterans Administration, Washington, D.C., and treasurer, Sister Mary Berenice, St. Louis. They will be installed at the next annual meeting of the Society to be held in Cincinnati in April.

Two hospital pharmacists have been elected to key posts in the American Pharmaceutical Association. Leo F. Godley, director of pharmacy service, Harris Hospital, Fort Worth, has been elected first vice president of the association. He is the immediate past president of the American Society of Hospital Pharmacists.

Dr. George F. Archambault, chief, pharmacy branch, Division of Hospitals, U.S. Public Health Service, Washington, D.C., has been reelected for a three-year term on the Council of the American Pharmaceutical Association. He is also a past president of the A.S.H.P.

The association elected Dr. Howard C. Newton, dean of Massachusetts College of Pharmacy, Boston, as its president.

Buffalo Record Librarian Heads National Body

Margaret Heath

BOSTON. — Margaret J. Heath, M.R.L., was installed as president of the American Association of Medical Record Librarians at the closing banquet of its 30th annual conference held here October 12 to 17. Miss Heath is associated with Buffalo General Hospital, Buffalo, N.Y. The 1957-58 president was Alta B. Mitchell.

Highlight of the convention was the annual Sister Patricia Memorial Lecture delivered by Kenneth G. Ryder, dean of administration at Northeastern University, Boston. Sister Patricia was a pioneer in the educational program for medical record librarians.

Dean Ryder prophesied more stringent demands on children at the lower levels of education and greater flexibility at the post-secondary school level. He thinks that the future training of lower school teachers will put more emphasis on subject matter and less on methods, while in college teaching the emphasis will be shifted to much needed methodology.

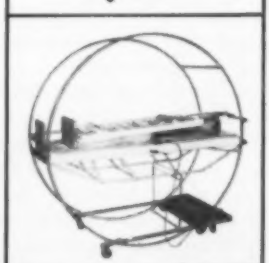
New York Hospital Council Elects New Vice President

NEW YORK. — The Rev. James H. Fitzpatrick, associate director, Division of Health and Hospitals, Catholic Charities, Diocese of Brooklyn, has been elected vice president of the Hospital Council of Greater New York, Dr. Hayden C. Nicholson, executive director of the council, announced.

Two new directors also elected are Mrs. George M. Billings, vice president of the Brooklyn Hospital, and Francis X. Stephens Jr., attorney.

Officers reelected were: president, Thomas J. Ross; vice presidents, Alvin C. Eurich and Dr. Martin R. Steinberg, and secretary, Cloyd Laporte.

A totally new concept in patient handling



Introducing

Stryker Circ O lectric

The new Circ O lectric Universal Hospital Bed is the first economical all-purpose unit developed for the comfort of the patient and for the convenience of the nurse.

Circ O lectric Bed advantages are many and varied . . . whenever special position is required and wherever patient handling is necessary. It features patient operated 180° electrical turning and 90° tilting with manual gatching. The bed can not only be used by the general surgeon and the orthopedic surgeon, but by many other specialists as well.

For additional information write, or call today.

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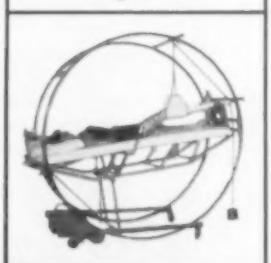
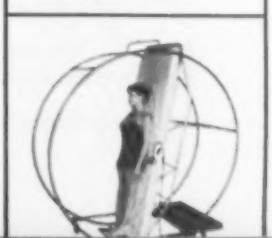




V.A. Issues Warning on Hospitalization Limitation

WASHINGTON, D.C. — Spanish-American War veterans should not assume that the Veterans Administration can pay bills for their care in non-V.A. hospitals, the agency has warned.

A substantial number of these veterans have entered private hospitals under the assumption that their care would be at V.A. expense and later found that they were not eligible.

The veterans and their families have had to accept responsibility for the cost of hospitalization, which often has been extensive.

The V.A. said some Spanish-American War veterans apparently have confused their eligibility for V.A. outpatient care with eligibility for hospitalization. Disabilities of Spanish-American War veterans are not automatically considered service-connected on application for hospital care as they are on application for V.A. outpatient care.

The agency can pay non-V.A. hospital bills of veterans only under certain limiting conditions. The veteran must require emergency hospital care for a service-connected disability for which delay in treatment or travel to the nearest V.A. hospital would be extremely hazardous.

United Funds Called Threat to Voluntary Agencies

NEW YORK. — The United Fund movement or combined fund raising appeals for health and community organization was described as a "serious threat" to voluntary national health agencies here last month.

The National Foundation, formerly the National Foundation for Infantile Paralysis, said its fund raising efforts and those of other voluntary health agencies would be "deprived of millions of dollars and the volunteers we need to raise our funds and carry out our programs" if the United Fund system continues to grow.

"The United Funds, having failed to force us into their combined drives and seeing some of the other voluntary national health agencies adopting nonparticipation policies, now are seeking to eliminate us and the other agencies from the voluntary health field," a *March of Dimes Newsletter* stated.

United Fund efforts are costing the Foundation and other agencies money, time and effort that should be devoted to their own programs, the newsletter continued.

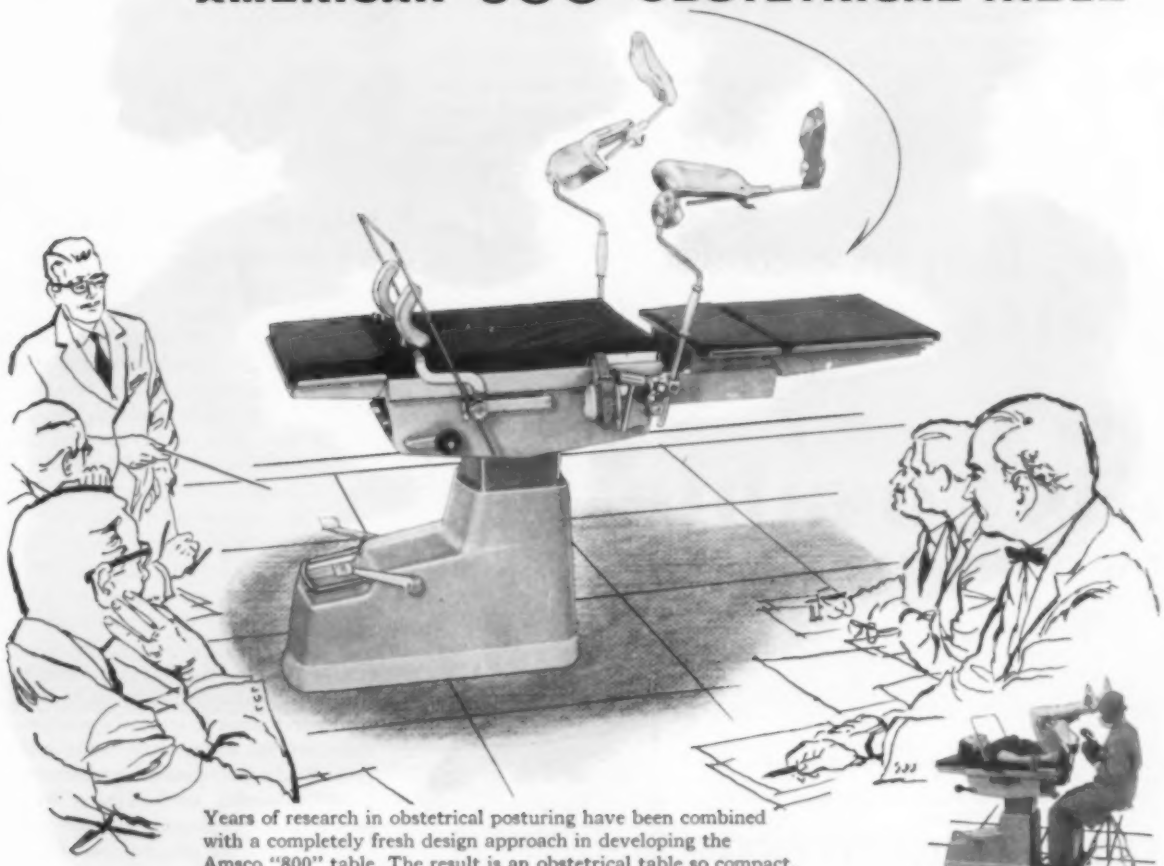
"Because the March of Dimes recognizes the giver's right to freedom of choice, it is true voluntary giving," the Foundation stated. "Our separate campaign is based on and preserves the American practice of groups of citizens banding together to plan, finance and carry out projects in which they are interested. It makes unnecessary governmental control of all health projects, financed by taxation.

"We have said in the past that, while we do not participate in United Funds, we do not oppose them. However, they have become so vicious in their tactics that they leave us no choice but to oppose them.

"The system they advocate and the methods they use are so bad, so contrary to voluntary giving and voluntary association, so violently different from our concept of the American way of life, that we must now oppose them both in principle and in practice."

The United Fund system is based on compulsion and regimentation, the Foundation concluded.

Presenting THE ALL NEW AMERICAN "800" OBSTETRICAL TABLE



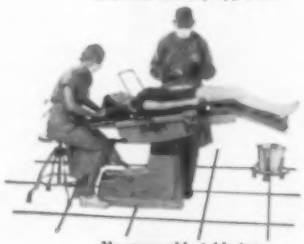
Years of research in obstetrical posturing have been combined with a completely fresh design approach in developing the Amsco "800" table. The result is an obstetrical table so compact, so maneuverable and so efficient as to be truly revolutionary in its advantages for operative as well as perineal route delivery.

From the narrow, flowing lines of the flexible top to the *permanent* or *portable* power base . . . the "800" is *new*.

Excellent delivery approach

Every Feature

- **finger-tip controls**
- **retractable foot section**
- **retractable 12" delivery shelf**
- **ratchet type legholder sockets**
- **flexible head and foot sections**
- **wide perineal opening for postpartum drainage**



Maneuverable table top

. . . each is new, exclusive and vital to the convenience of the obstetrician and the welfare of the patient.

Every hospital and every obstetrician will have a direct interest in this dramatically better table. Fully illustrated brochure TC-224-R is available without obligation.

Unobstructed surgical approach

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World's largest designer and manufacturer of Sterilizers, Operating Tables, Lights and related hospital equipment

For additional information, use postcard facing Cover 3.

High Costs Blamed on Extravagant Use of Plans

CLEVELAND. — One reason hospital costs are rising is that "too many people continue to make extravagant use of hospitalization plans," the *Cleveland Press* said in an editorial last month.

The *Press*, commenting on an increase in Blue Cross rates, said another reason is that hospital costs have continued to rise.

The answer to hospital costs lies with the hospitals, the editorial stated.

"As long as hospitals can keep boosting rates, and as long as the Blue Cross keeps paying, there's no particular incentive to apply the brakes," the newspaper said. "But if the pressure to hold costs down gets stiff enough, it's a safe bet the hospitals will find a way, just like any business must."

The answer to over-use of hospitalization plans lies with patients and doctors, the editorial continued.

"If patients continue to rush to hospitals for services they could get just as well somewhere else, they'll have to pay the price," it said. "And the doctors who send them to hospitals play a big part, too, in the upward surge of Blue Cross rates."

The state superintendent of insurance, who has been called on to approve a proposed increase in Blue Cross rates, should call public hearings and "take a long and careful look at the proposition," the paper said.

"At the very least, he can bring out the facts, so the public will know why prices are still going up," the editorial concluded. "At the best, he can demand the cost saving efforts and tighter control of hospital use which so far have only been promised."

Michigan To Study Medical and Hospital Economics

ANN ARBOR, MICH.—A comprehensive study of hospital and medical economics in Michigan will be carried out by the University of Michigan under a two-year grant of $324,760 from the W. K. Kellogg Foundation, Battle Creek. The study, to be directed by Walter J. McNerney, head of the bureau of hospital administration in the school of business administration, is scheduled to begin this month. It will:

1. Survey hospitals, allied institutions, and agents in terms of services offered, general program, effectiveness of organization, and cost elements.
2. Examine hospital and medical prepayment and insurance plans with specific reference to internal operation, costs, benefits and contract limitations.
3. Study the relationships between contract benefits, availability of services, and use of benefits and services.
4. Examine the effectiveness of various proposals to control costs.
5. Survey a sample of the population to determine its health experience, charges incurred, amount of insurance coverage, and current disability.

Says Hospital Use To Rise

CLEVELAND. — Countrywide use of hospitals is likely to increase as much as 50 per cent in the next 20 years, George Bugbee, president of the Health Information Foundation, predicted recently. "More people are becoming expert in the utilization of medical care and expose themselves to the many types of health services now available, not only to extend life but to minimize pain and disability. Moreover, with a population expected to grow to about 225 million by 1975, the demand created may be literally staggering," Mr. Bugbee said.

Another New Private Room Grouping in Teakwood Grain Farlite

(designed by Raymond Loewy)

Here is another beautiful private room featuring the new Hill-Rom No. 8500 Grouping designed by Raymond Loewy and finished in No. 85 Teakwood Grain Farlite. The bed, beside cabinet and straight chair all share in the beauty and utility of this high pressure laminated plastic, combined with Satin Stainless and Loewy Charcoal.

As in all Hill-Rom designs, every item in this grouping has been scaled down to appropriate size for today's small hospital rooms. No longer is it necessary to crowd these small rooms with furniture designed for the larger rooms of several years ago—another "Hill-Rom First."

HILL-ROM
8500
SERIES

Included in the above room scene are: No. 85-65 All-Electric (Push-Button control) Hi-low Bed; No. 8503 Bedside Cabinet; No. 85-614 Overbed Table; No. 8507 Straight Chair; No. 8508 Arm Chair, and No. 306 Lamp. This furniture is ample for a room with a built-in wardrobe dresser. If drawer space is required, we offer No. 8526 Chest Desk. Catalog picturing and describing all of these items will be sent on request.

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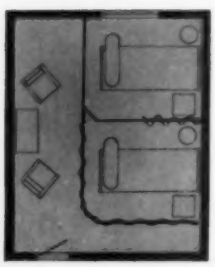
"PERFECTED" CUBICLE SCREENING

. . . for wards, semi-private rooms, dressing rooms



private room convenience and appearance in semi-private rooms

Typical floor plan of suggested screening arrangement for semi-private room. Each bed can be entirely closed, thus giving both patients complete privacy—an advantage not obtainable with a single track installation.

Hill-Rom Screening gives privacy and convenience to semi-private rooms and wards. It does this without detracting from the appearance, as shown in the above picture. This bright, cheerful ward is completely equipped with Hill-Rom Screening, but when the curtains are not drawn the screening equipment is hardly noticed. No unsightly posts or pipes—no floor obstructions—maximum working area for doctor and nurse.

The same efficient "I" beam track system is available in a choice of installation methods. Suspended or surface mounted screening for existing or new areas. A proven Recessed-in-Ceiling cubicle when desirable for new construction. All types assure smooth, quiet, trouble-free performance and are immediately available in standard units which permit proper screening of any size or shape rooms.

Hill-Rom permanently flameproof Safety Curtains provide the utmost protection against fire, and are the ideal replacement for existing screening jobs. Even under intense fire the material in these curtains will not support a flame. It will only char. Even repeated launderings, with any type of soap or detergent, will not affect this flame-proof quality. Available in cream, peach, and green shades.

Specifications and complete information on screening promptly sent on request.

HILL-ROM COMPANY, INC. • BATESVILLE, INDIANA

Nurses Will Need More Education in Future, Nebraska Group Is Told

OMAHA, NEB. — Nurses will need more rather than less education in the future to meet the demands of hospital nursing service, Dr. T. Stewart Hamilton, director of the Hartford Hospital, Hartford, Conn., and chairman of the American Hospital Association's Council on Professional Practice, said in an address to the opening session of the 22d convention of the Nebraska Hospital Association here last month.

More than 500 hospital administrators, trustees, medical staff officers, auxiliary members, and departmental executives took part in the two-day program of lectures, conferences and panel discussions.

Paul E. Finnman, administrator of North Platte Memorial Hospital, was named president-elect of the association at the annual business meeting. Mr. Finnman will succeed Joseph O. Burger, trustee of Nebraska Methodist Hospital, Omaha, who became president during the convention, succeeding Gerald L. Aldridge, Mary Lanning Memorial Hospital, Hastings.

As medical science becomes more complex, the physician has to leave more and more medical procedures to be performed by the nurse, Dr. Hamilton stated. "As he leaves more to her and expects more of her, she must be better equipped," he pointed out. "The better the preparation the better the job done."

Moreover, Dr. Hamilton said, nurses in the future will need more administrative and supervisory skills than have been required in the past, to meet the demands of nursing floors on which an increasing volume of service is delivered by auxiliary nursing personnel.

"As times change and we ask more and more in the way of administrative and supervisory skills of our nurses, shouldn't we gear our aptitude examinations to give this more weight?" he asked.

"Administrative tasks are the bane of any nurse's day," Dr. Hamilton said. "How much of this administrative skill can we impart to a young woman if we have selected her because she possesses other and perhaps conflicting attributes?"

Dr. Hamilton said the training of nurses in the future must remain hospital-centered, however. "The education of nurses in hospital schools of

(*Continued on Page* 190)

FIVE DIFFERENT TYPES OF AIR FILTERS IN THIS HOSPITAL

...and they're all AAF filters!

No single type of air filter can meet all the clean-air needs of the modern hospital. Different areas—kitchen, laundry, private rooms, wards, surgery rooms—*demand* different degrees of clean air.

A case in point—St. John's Hospital, Tulsa, Oklahoma. St. John's is using five distinctly different types of filters because they *need* five different types. That's precisely why AAF *makes* a complete line.

Before selecting your filters, talk with the company that *offers* a selection. Let us show you how our complete-line approach assures you of the *right* filter installation.

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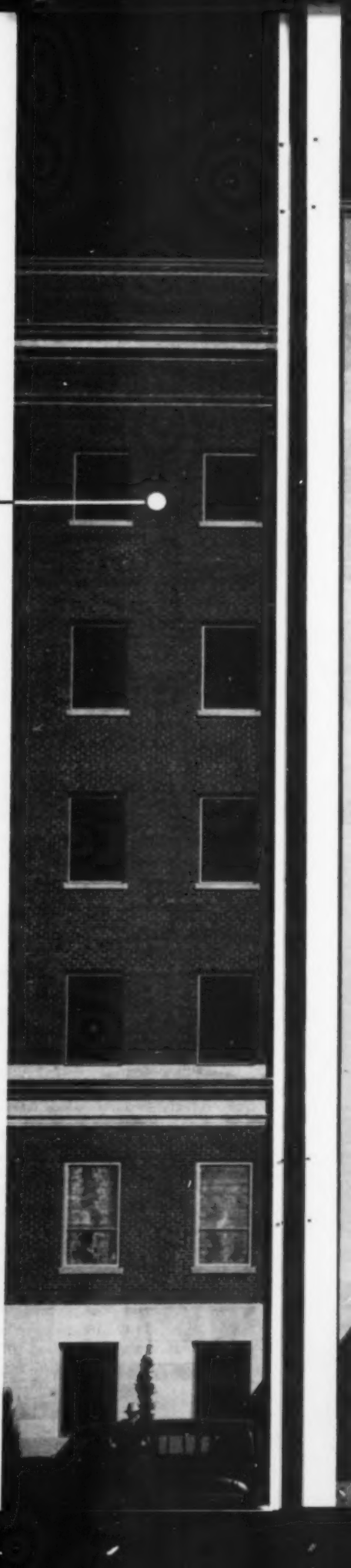
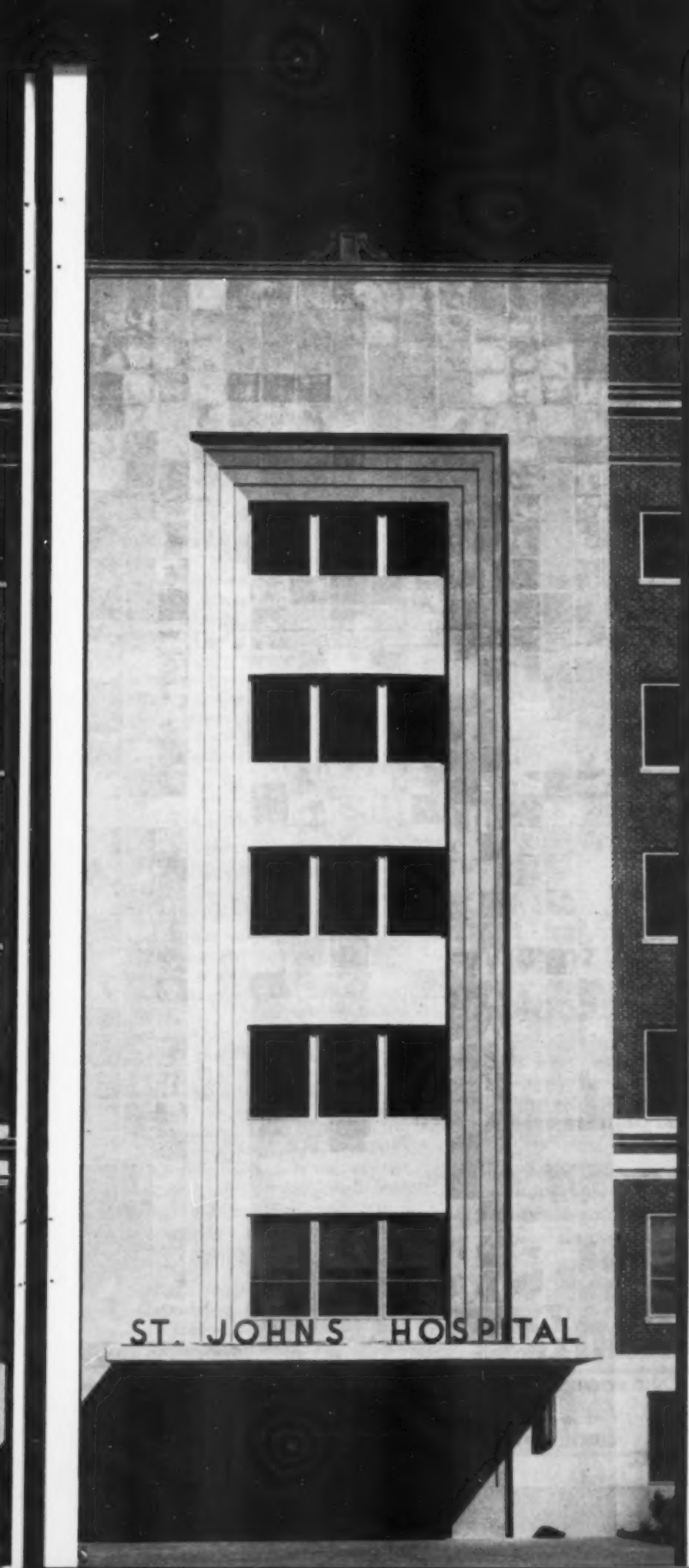
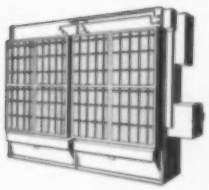
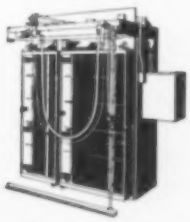
Architect: Leon B. Senter, Tulsa; Mechanical Plans by John C. Penafeather of the architect's office; Mechanical Contractor: Watt Plumbing, Air Conditioning and Electric Company, Tulsa.







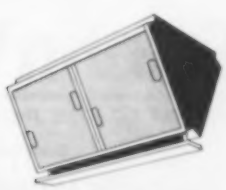
ROOMS AND WARDS. St. John's assures super-clean air for general ventilation with the AAF Electro-Matic filter. This automatic, self-cleaning electrostatic precipitator removes the tiniest dust particles from the air and automatically cleans itself at the same time!



SURGERY ROOMS. Here, also, electrostatically clean air was called for. Space limitations suggested the use of the AAF Electro-CELL—sectional construction offers advantages in simplified installation.

LAUNDRY. Laundry exhaust air contains plenty of lint. AAF's lint filter—the automatic, self-cleaning Auto-AIRMAT—traps the lint and winds it up in a handy disposable roll.

KITCHEN. The AAF Roll-O-Matic is filtering the air going into St. John's kitchen. This self-cleaning, renewable-media filter operates up to a year without maintenance, and replacing media is as simple as changing film in your camera.



KITCHEN EXHAUST. The AAF Grease Filter is eliminating fire hazards and reducing duct maintenance in St. John's kitchen. Installed directly above grease-producing areas, the Grease Filter is a permanent, washable filter.

(*Continued From Page* 187)
nursing will and must continue until some drastic change in our social situation makes some other means of educating nurses more practical," he said.

Beginning salaries for nurses are now adequate on the whole, Dr. Hamilton told reporters at a press conference preceding his lecture, but "the ceilings need to be raised," he added. Opportunities for advancement in nursing must be enlarged to make the profession more attractive, he said.

"Nursing should be a rewarding career for a span of 40 years, not merely from 21 to 24 and from widowhood to retirement," he declared.

In an address presented at the association's annual banquet, Dr. F. J. L. Blasingame, executive vice president of the American Medical Association, warned against the intrusion of third parties in the doctor-patient relation.

Whether the third party is the government, labor, industry or an independent lay group, Dr. Blasingame said, there is danger it may control medical facilities and services by stipulating the conditions under which payment for service can be made.

Dr. Blasingame welcomed hospital administrators and trustees as members of the health team and urged closer communication and cooperation among all groups concerned with health services.

Moreover, he concluded: "It is most essential that the health team communicate with the public to let people know what is being done in medicine and what can be done."

In a final session, Richard M. Jones, director of the Blue Cross Commission, Chicago, denied there is serious overutilization of hospital facilities and services, as has been charged in public hearings on Blue Cross rates in some areas of the country.

Before any charge of overutilization can be fairly established, Mr. Jones said, there must be some definition of what constitutes normal utilization.

No such definition of normal use of hospital facilities has been established anywhere, he asserted.

Hospitals need to answer charges of overutilization and inefficiency that have been made, Mr. Jones said.

"Nobody knows our business better than we do, and we need to say so," he declared.

Public Health Officer Says Britain "Better Off" in Health Service

CHICAGO. — American critics to the contrary, the British people are getting better care today under the National Health Service than they were before the service was inaugurated 10 years ago, a British public health official declared here last month.

Dr. John Scott, principal health officer of the London County Council, said in an interview that 97 per cent of the British population believe they are better off under the National Health Service than they were before. This view is shared by approximately 80 per cent of doctors in Britain, he added.

Dr. Scott predicted that "one of these days" the United States will have some form of nationalized plan to make certain that U.S. citizens get medical service at the time it is needed. However, he acknowledged, the American plan would not necessarily resemble the British Health Service.

"What works for us might not work for you," he stated.

The independence of the medical profession has not been sacrificed in the operation of the National Health

Every bottle "kitchen clean"

How our "automated housewife" protects the quality of 7-Up

Your 7-Up bottling plant rivals today's modern kitchen in cleanliness. The mechanical marvel shown here, for example, washes 360 bottles a minute in solutions that leave each one chemically and bacteriologically clean.

No dish at home ever received better treatment. That's one reason why you can drink safely right from the 7-Up bottle . . . and another reason why every sip of 7-Up is uniformly delicious, refreshing, wholesome. Yes, cleanliness pays.

Such conscientious control extends through every phase of 7-Up production. Bottles are filled and capped by immaculate stainless steel machines immediately after their thorough washing. At every step of the way we've established sanitary safeguards that protect the quality of 7-Up.

Seven-Up . . . the pure, wholesome "All-Family Drink".

Nothing does it like Seven-Up!

Service in Britain, Dr. Scott insisted.

"You have got to safeguard the conditions under which the doctor can do the best work for his patients," he said. This has been done in Britain, he added, although he said there was a small minority of British physicians still opposed to the National Health Service.

Among the principal problems that remain to be solved after 10 years of operation under the National Health Service, Dr. Scott named:

1. Lack of resources for capital improvement of British hospitals.
2. Insufficient number of consultant (hospital staff) appointments for registrars (residents) who are completing their specialty training.
3. Lack of opportunities for young general practitioners to get started.

Dr. Scott denied that the National Health Service has resulted in loss of interest in the medical profession as a career on the part of well qualified young men. British medical schools are accepting only one out of every four applications currently, he pointed out — a record that compares favorably with the experience of American medical schools.

While there are waiting lists for admissions to British hospitals, the delays in hospital admissions have been used "polemically" in the United States as an argument against the effectiveness of the National Health Service in Britain, Dr. Scott charged. Waiting lists consist entirely of patients awaiting elective surgery, and all emergency and urgent conditions are treated promptly in hospitals, he reported.

"Egg-Shaped" Operating Rooms Are Functional

COPENHAGEN, Denmark. — Six "egg-shaped" operating rooms are features of an ultramodern hospital opened here in September. They are planned around the different functions that occur in an operation, and are said to represent the first complete synthesis in operating room design.

"All relevant factors have been integrated into a controlled form. As a result, the egg-shaped room is more than space; it has become an instrument," said Paul Nelson, U.S. architect.

Features of the rooms include 71 lighting projectors arranged to give surgeons a multiplicity of lighting possibilities, easier separation of sterile from nonsterile zones, and elimination of projecting fixtures.

here's a NURSE CALL SYSTEM THAT SAVES MONEY

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ABOUT PEOPLE

(*Continued From Page* 100)

was formerly administrative assistant at Massachusetts General Hospital, Boston, and is a graduate of the School of Public Health and Administrative Medicine of Columbia University.

Frank J. De Scipio, formerly assistant superintendent of Manhattan Eye, Ear and Throat Hospital, New York, has been appointed assistant administrator of Peabody Home, New York. He was graduated from the School of Public Health and Administrative Medicine of Columbia University.

Marshall G. Ause, administrator of Lutheran Medical Center, Brooklyn, has been elected a trustee of the Lutheran Hospital Association of America. He is president-elect of the University of Minnesota Hospital Administrators Alumni and president-elect of the Brooklyn-Long Island-Staten Island Hospital Council.

Kenneth L. Waddell has been appointed administrator of Waddell Hospital and Clinic, Galax, Va. He received his master's degree in hospital administration from the Medical College of Virginia. He has served residencies there and at Louise Obici Memorial Hospital and Franklin Memorial Hospital, also in Virginia.

Martin Freiwirth has been appointed assistant executive director of Workman's Circle Home for the Aged, Bronx, N. Y. He is a graduate of the Columbia University program in hospital administration.

Mother M. Michael, C.R.S.M., has been appointed director for hospitals of the Sisters of Mercy of Philadelphia. The appointment of **Sister Marie Immaculate** as administrator of Misericordia Hospital, Philadelphia, and of **Sister Marie** as administrator of Fitzgerald-Mercy, Darby, Pa., was also announced.

George Ryan has resigned as administrator of Citizens Memorial Hospital, Victoria, Tex.

Arthur Wilson has been appointed administrator of Saline Memorial Hospital, Benton, Ark.

Bernard Weinstein has been named administrative assistant at Albert Einstein Medical Center, Philadelphia.

David Hitt has been promoted to associate administrator and **John Towers** to assistant administrator of Baylor University Hospital, Dallas.

Charles Knechtel, administrator of Ellensburg General Hospital, Ellensburg, Wash., has resigned to become business manager of the state school for retarded children at Selah, Wash.

Sister M. Sponsaria

Sister M. Sponsaria has been named administrator of St. Alexis Hospital, Cleveland, succeeding **Sister M. Helen Agnes.** Sister Sponsaria has been administrator of St. James Hospital, Chicago Heights, Ill.; St. Joseph's Hospital, Memphis, Tenn., and St. Elizabeth's Hospital, Lafayette, Ind. For the last seven years she has served as assistant administrator and business office supervisor at St. Francis Hospital, Evanston, Ill. Also announced was the appointment of **Sister M. Wilberta** as director of nursing. For the last two years she has been director of nursing service at St. Elizabeth's Hospital, Lafayette, Ind. She succeeds **Sister M. Alvera.**

Maj. Gen. Oliver K. Niess has been appointed surgeon general of the U.S. Air Force succeeding **Maj. Gen. Dan**

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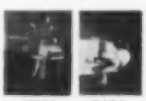

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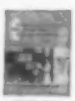

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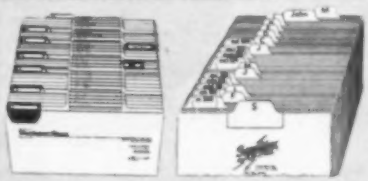

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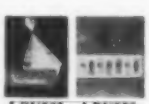

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C. Ogle, who has retired after almost 30 years' active service. Gen. Niess was formerly command surgeon of the Pacific Air Forces in Hawaii. He is a fellow of the American College of Surgeons.

Marshall C. Petring has been appointed administrative assistant at Cleveland Metropolitan General Hospital of Cuyahoga County, Cleveland. He is a graduate of the University of Chicago program in hospital administration.

Russell T. Clayton has been appointed assistant administrator of Baroness Erlanger Hospital, T. C. Thompson Children's Hospital and Carver Hospital, Chattanooga, Tenn. **Woodrow Wilson Fanning,** former assistant administrator at Erlanger Hospital, has been named administrator of Bristol Memorial Hospital, Bristol, Tenn., succeeding **John C. Gilbert Jr.,** who resigned.

Edward Ackerman, formerly assistant administrator of Binghamton City Hospital, Binghamton, N. Y., has been appointed administrator of Fox Memorial Hospital, Oneonta, N. Y.

John C. Barker is the new director of Maine Medical Center, Portland, succeeding **Donald M. Rosenberger,** who has become head of United Hospitals of Newark, N. J. Mr. Barker, formerly assistant director of the hospital, is a member of the American College of Hospital Administrators.

Charles H. Frenzel has been appointed superintendent of Duke Hospital, Durham, N. C., succeeding **F. Ross Porter,** who has resigned to organize a foundation for the Duke University Medical Center. Mr. Frenzel, formerly assistant administrator, is a graduate of the Duke University program in hospital administration.

Dr. Edward F. Zimmerman has been appointed manager of Veterans Administration West Side Hospital, Chicago. He was formerly director of professional services at the Coral Gables, Fla., Veterans Administration Hospital.

Lawrence Trousdale, administrator of St. Luke's Hospital, Spokane, for the last seven years, has resigned. **Adam Coutts,** assistant administrator, has also resigned.

Sister Mary Edith is the new administrator of Ohio Valley General Hospital, McKees Rocks, Pa., succeeding **Mother Margaret Mary.** Sister Edith had been at the hospital from 1930 to 1952 when she began the course in hospital administration at St. Louis University. Upon graduation, she became administrator of Mercy Hospital, Altoona, Pa.

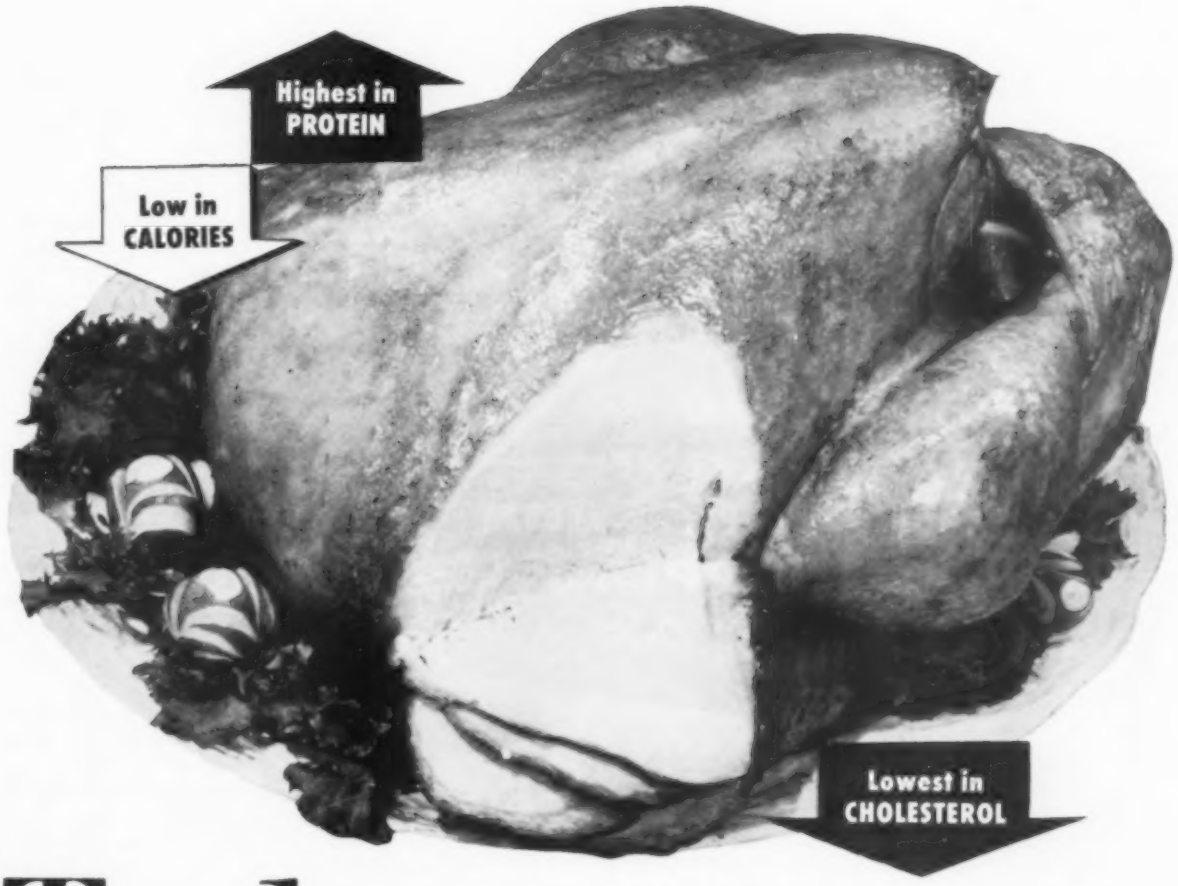
Sister Marie Vianney, former administrator of St. Joseph's Hospital, Paris, Tex., has been appointed administrator of St. Anthony's Hospital, Amarillo, Tex. She has been succeeded at St. Joseph's by **Sister Mary Nicholas,** former administrator of St. Anthony's.

Jaromir Marik has been named assistant administrator at Pennsylvania Hospital, Philadelphia. He had been administrative assistant at Vancouver General Hospital, Vancouver, B. C.

Eleanor Hurd, director of nursing, has been appointed assistant administrator of Windham Community Memorial Hospital, Willimantic, Conn. She will be succeeded in her present post by **Barbara Kane,** currently with the Yale-New Haven Medical Center.

Edmund J. McTernan has been appointed administrative assistant of Malden Hospital, Malden, Mass. He is a graduate of New England College and holds a master's degree from Columbia University.

Sister Marie Breitling, administrator



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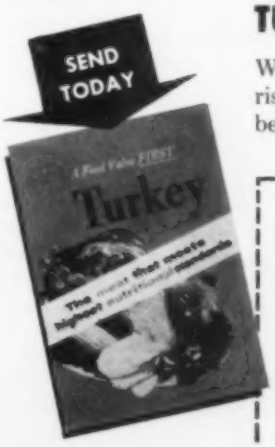

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of Seton Hospital, Austin, Tex., has been transferred to St. Joseph's Hospital, Chicago. **Sister Alphonsine Casey** has been appointed administrator of Seton Hospital.

Floyd Parrish, assistant administrator, Meriden Hospital, Meriden, Conn., has been appointed director of Sailors' Snug Harbor, New York. He is a graduate of the Yale University course in hospital administration and served his residency at Greenwich Hospital, Greenwich, Conn.

Robert C. Taylor has been appointed administrator of Hillcrest Hospital, Petaluma, Calif., succeeding **Howard E. Johnson.**

Fred F. Ellison has been named administrator of Oconee Memorial Hospital, Seneca, S.C., succeeding **Calvin Milton Snipes.** Mr. Ellison formerly was administrator of Tri-City Hospital, Leakesville, N.C. He also served as assistant superintendent of Greenville General Hospital, Greenville, S.C.

Geneva Bemis has been named assistant administrator of the new Glendora Hospital, Glendora, Calif.

William Burge, former administrator of Titus County Memorial Hospital, Mt. Pleasant, Tex., has been appointed administrator of Val Verde Hospital, Del Rio, Tex. The hospital is scheduled to be opened in January.

Sister Martha has been named assistant administrator of Spencer Hospital, Meadville, Pa. Prior to becoming a staff member at Meadville three years ago, Sister Martha was administrator of St. Mary's Geriatric Hospital and Home, Erie, Pa.

Charles W. Pruitt Jr. has been appointed assistant director of hospital and clinics, in charge of clinics and the outpatient department, at J. Hillis Miller Health Center, Gainesville, Fla. He has been administrative assistant to the provost of the health center since 1954.

Sister Mary Alfreda has been appointed administrator of Sacred Heart Hospital, Lamar, Colo., replacing **Sister Mary Pauline.**

Michael O'Conner has been named administrator of Lee Memorial Hospital, Marianna, Ark.

Freida E. Enss has been appointed assistant administrator of St. Louis Children's Hospital, St. Louis.

W. J. Dye has been appointed administrator of the newly reorganized Woodcroft Hospital, Pueblo, Colo. He was formerly administrator of Mennonite Hospital, La Junta, Colo. **Luke Birky,** formerly administrator of Pioneers Hospital, Rocky Ford, Colo., has been named administrator at Mennonite Hospital.

Stuart Short has been appointed administrator of Perry County Hospital, Perryville, Mo.

Ferrell B. Driskell has resigned as administrator of Rhea County Memorial Hospital, Dayton, Tenn. **E. Fred Horn,** formerly administrator of Hamilton Memorial Hospital, Jasper, Fla., has been appointed to succeed Mr. Driskell.

Sister M. Ferdinand, former administrator of St. Luke's Hospital, Marion, Kan., has been named administrator of Villa Madonna Hospital, Enid, Okla. She succeeds **Sister M. Zenona,** who has been transferred to Marion, Kan.

Kenneth Hager, formerly associated with the Turnbow Clinic, Tulsa, Okla., has been named administrator of Hominy City Hospital, Hominy, Okla. He succeeds **Louis L. Zmek,** who has been appointed assistant administrator of Benedictine Heights Hospital, Guthrie, Okla.

Gladys J. Sharpe, formerly director of nursing at Toronto Western Hospi-

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tal, Toronto, Ont., has been appointed to the Ontario Hospital Services Commission.

Bernard McCarthy has been appointed administrative assistant to the executive-secretary of the Ontario Hospital Association. He formerly was administrative assistant at Pennsylvania Hospital, Philadelphia. He is a graduate of the hospital administration course at the University of Toronto, and served his residency at Toronto East General and Orthopedic Hospital, Toronto, Ont.

Dr. James E. Cassidy has been named assistant director and chief of the medical unit of the student health service of the University of Chicago. He also will be assistant professor of medicine.

Sister Mildred of Providence has been appointed administrator of St. John's Hospital, Port Townsend, Wash., succeeding **Sister Zephirin.**

Sister Brendan, previously administrator of St. Patrick's Hospital, Missoula, Mont., is new administrator of St. Ignatius Hospital, Colfax, Wash., succeeding **Sister Amedee Marie.**

Blackshear Jameson has been appointed administrator of Hurst Eye, Ear, Nose and Throat Hospital-Clinic, Longview, Tex.

Paul Moore, former administrator of Trigg County Hospital, Cadiz, Ky., has been named administrator of the City-County Hospital now under construction in Lexington, Tenn.

Harry O. Davis has been named administrator of Fredericksburg Hospital and Clinic, Fredericksburg, Tex.

Department Heads

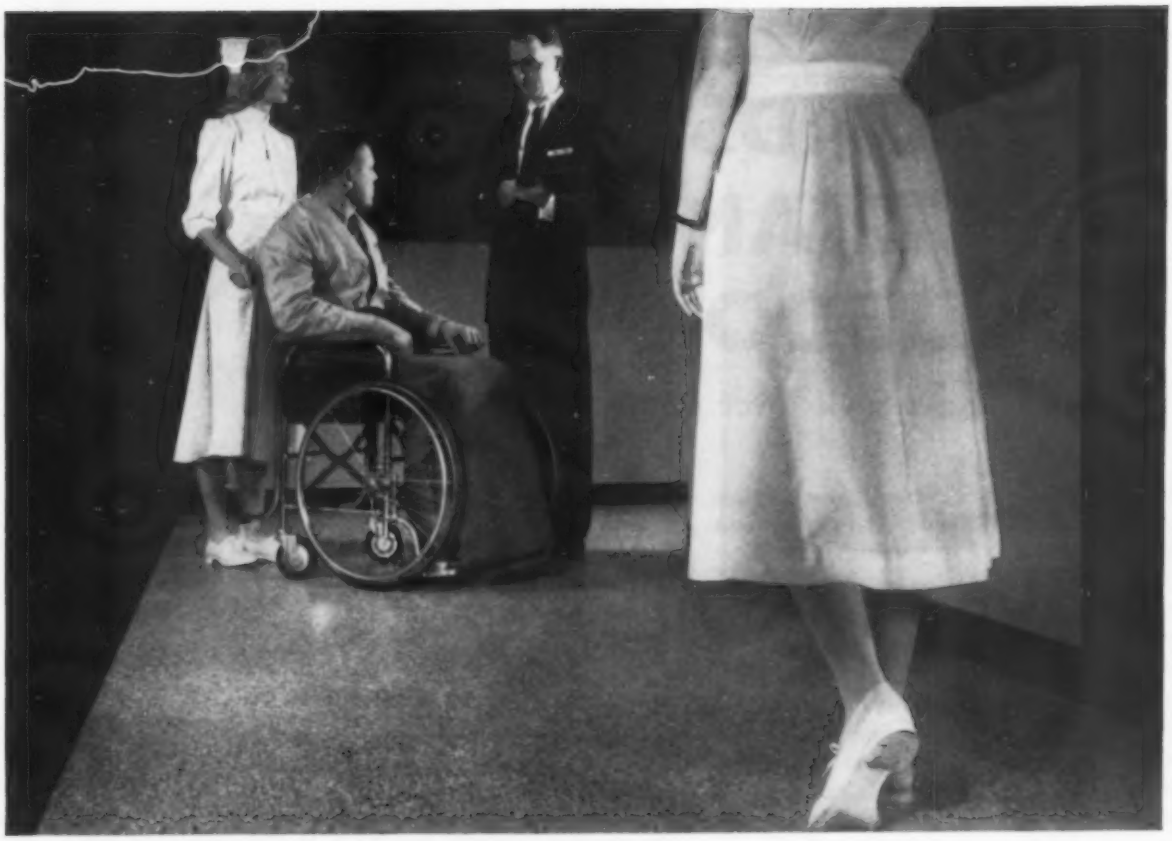
Paul Whitall is the new controller of Episcopal Hospital, Philadelphia.

Bob Stevenson, business manager, Methodist Hospital, Houston, has been appointed business manager of All Saints Hospital, Fort Worth, Tex.

John P. Hyden has been appointed director of personnel at St. Francis Hospital, Evanston, Ill. He was previously on the faculty of Vanderbilt University and served seven years in Army hospital administrative posts.

Sister M. Antonette, formerly director of nursing personnel at St. Anthony Hospital, Denver, has been named assistant director to coordinate professional services at Creighton Memorial St. Joseph's Hospital, Omaha. Also announced were appointments of **Sister M. Edmondine** as medical record librarian and **Sister M. John Francis** as

(*Continued on Page* 205)



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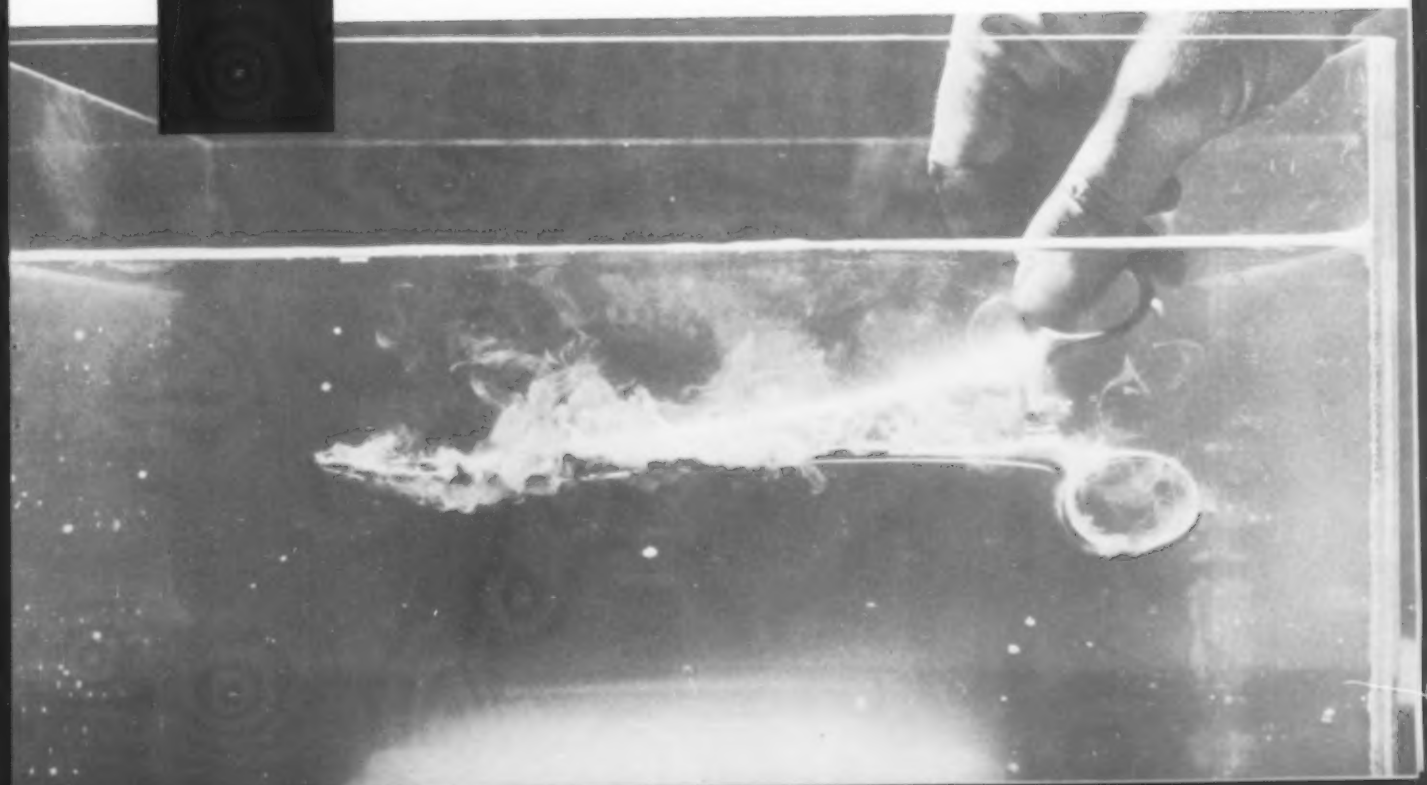

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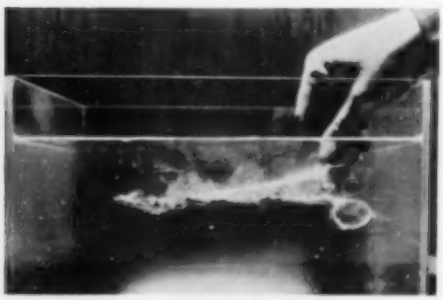

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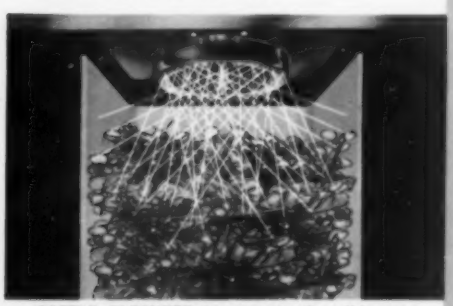

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(*Continued From Page 200*)

supervisor of the x-ray department, succeeding **Sister M. Liberia,** who has retired.

John Conditt has been appointed assistant business manager of Arlington Memorial Hospital, Arlington, Tex.

Dr. Franklin C. Fetter has been appointed director of medical education at Presbyterian Hospital, Philadelphia.

Richard Drozda has been named controller at Lincoln General Hospital, Lincoln, Neb., succeeding **Arthur Sallee.**

Robert L. Norris has been appointed to the newly created post of purchasing agent at Boone County Hospital, Columbia, Mo. He will assume the position January 1, when his term as judge of the county court expires.

Perry Balzer has been appointed controller of American Oncologic Hospital, Philadelphia.

Helen Wilks has been named dietitian at Marion County General Hospital, Columbia, Miss. She is a graduate of Mississippi Southern College, and was employed previously at Southern Baptist Hospital, New Orleans.

Henry T. Wilson has been appointed director of the progress fund of Danbury Hospital, Danbury, Conn. For the last five years, Mr. Wilson has directed public relations and fund raising for the Crotched Mountain Foundation, Greenfield, N.H.

Earnil D. Zornes Jr. has been appointed business manager of the East Coast Hospital Association, St. Augustine, Fla. Mr. Zornes is a graduate of Marshall College, Huntington, W. Va., and until recently was a member of the administrative staff there.

Charles E. Schmitt is the new vocational director of rehabilitation at St. Mark's Hospital, Salt Lake City. He holds a master's degree in educational psychology from the University of Utah. He interned in the state office of rehabilitation, Odgen, Utah.

Miscellaneous

Oscar Kurren has been appointed consultant on rehabilitation centers for the National Society for Crippled Children and Adults. For the last four years he has been executive director of Harmarville Rehabilitation Center, Pittsburgh, which he established as Harmarville Convalescent Home. He also served as rehabilitation supervisor for the State Council for the Blind of Pennsylvania, medical social consultant of the central office department of public assistance, and medical social worker for the Veterans Administration Hospital, Pittsburgh.

Capt. Leo J. Elsasser has been appointed chief of the Navy Medical Service Corps, succeeding **Capt. Willard C. Calkins,** who has retired after more than 39 years of active naval service. Capt. Elsasser has been administrative officer of the naval hospitals at Chelsea, Mass.; San Diego, Calif., and Great Lakes, Ill. He was the first director of the hospital administration division of the navy's bureau of medicine and surgery. For the last year he was commanding officer of the Naval School of Hospital Administration, Bethesda, Md., and a consultant in hospital administration to the surgeon general of the navy. He has served on the American Hospital Association Council on Planning, Financing and Prepayment.

Deaths

Dr. James W. Murdoch, general superintendent of the North Carolina mental hospital system since 1955, died September 16 at the age of 58. A native of Scotland, he came to this

country in 1947 and became head of Butner State Hospital, Butner, N. C. He received his medical education at the University of Aberdeen, Scotland.

Sister Superior Mary Seraphim, administrator of St. Michael's Hospital, Newark, N. J., died September 26 at the age of 69. She had served previously as sister superior of St. Francis Hospital, New York, and St. Mary's Hospital, Hoboken, N. J. She had been coordinator of training schools of hospitals operated by the Order of the Sisters of the Poor of St. Francis for 15 years.

COMING EVENTS

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Region I, Boston, Nov. 10-14; Region 8, East Lansing, Mich., Nov. 17-21.

ARIZONA HOSPITAL ASSOCIATION Westward-Ho Hotel, Phoenix, Nov. 13, 14.

KANSAS HOSPITAL ASSOCIATION, Baker Hotel, Hutchinson, Nov. 13, 14.

LOUISIANA HOSPITAL ASSOCIATION, Bellemont Motor Hotel, Baton Rouge, March 5-7.

MISSOURI HOSPITAL ASSOCIATION, President Hotel, Kansas City, Nov. 19-21.

VIRGINIA HOSPITAL ASSOCIATION, Hotel Roanoke, Roanoke, Nov. 14-16.

1959

ALABAMA HOSPITAL ASSOCIATION, Admiral Semmes Hotel, Mobile, Jan. 23, 24.

AMERICAN HOSPITAL ASSOCIATION, The Coliseum, New York, Aug. 24-27.

AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, Sheraton-Palace Hotel, San Francisco, March 30-April 1.

ASSOCIATION OF OPERATING ROOM NURSES, Shamrock-Hilton Hotel, Houston, Feb. 9-11.

ASSOCIATION OF WESTERN HOSPITALS, Hotel and Motel Utah, Salt Lake City, May 4-7.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Hotel Roanoke, Roanoke, Va., April 8-10.

CATHOLIC HOSPITAL ASSOCIATION, Kiel Auditorium, St. Louis, June 1-4.

GEORGIA HOSPITAL ASSOCIATION, Bon Air Hotel, Augusta, March 5, 6.

KENTUCKY HOSPITAL ASSOCIATION, Phoenix Hotel, Lexington, Mar. 31-April 2.

MAINE HOSPITAL ASSOCIATION, Hotel Samoset, Rockland, June 2, 3.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Hotel Shoreham, Washington, D. C., Oct. 26-28.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N. J., May 20-22.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, Mo., April 1-3.

NATIONAL REHABILITATION ASSOCIATION, Boston, Oct. 26-28.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 23-25.

OHIO HOSPITAL ASSOCIATION, Deshler-Hilton Hotel and Veterans Memorial Auditorium, Columbus, April 6-9.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta-Biltmore Hotel, Atlanta, April 8-10.

TENNESSEE HOSPITAL ASSOCIATION, Andrew Jackson Hotel, Nashville, May 7-8.

TEXAS HOSPITAL ASSOCIATION, Shamrock-Hilton Hotel, Houston, May 12-14.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 27-29.

UPPER MIDWEST HOSPITAL CONFERENCE, St. Paul Auditorium, St. Paul, May 13-15.

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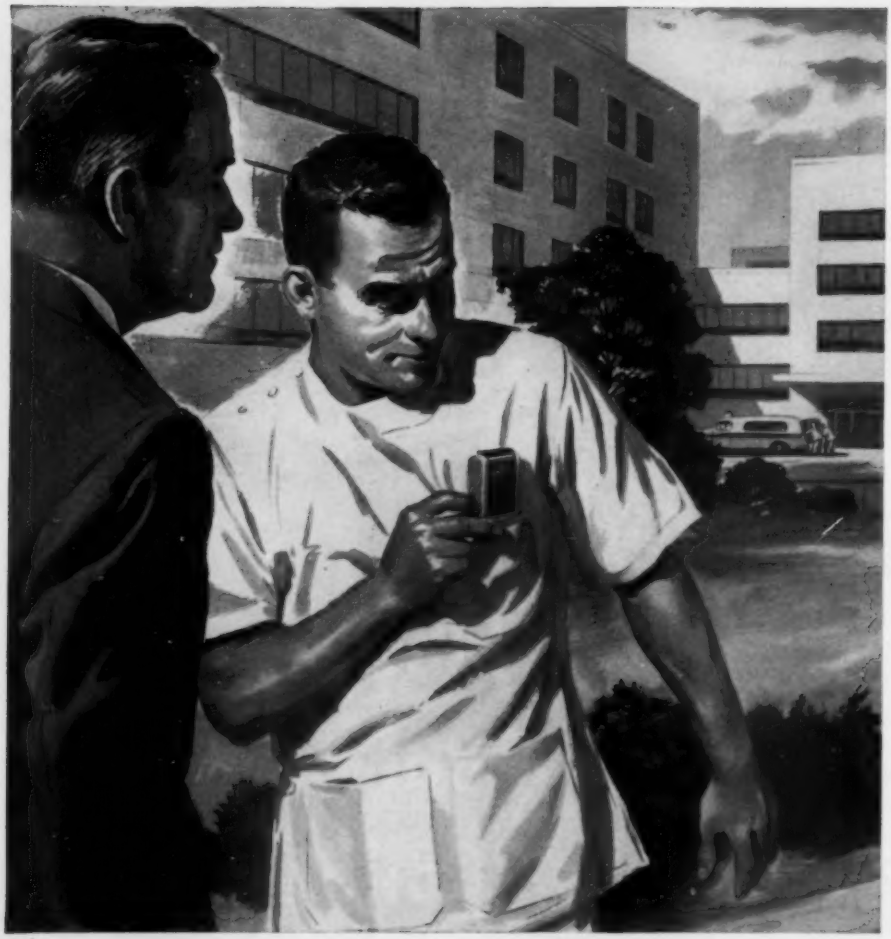

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ADMINISTRATOR—13 years, experienced personnel, public relations, construction, excellent references, desires 125-175 beds in or near city, Southwest or Florida preferred; currently employed. Apply MW 44, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ANESTHETIST—Nurse; 48; with years of anesthesia experience, intubation anesthesia included; get along well with young people; references furnished; will locate in any part of the U.S. Apply MW 42, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ENGINEER—Plant-Chief or maintenance superintendent; university graduate in mechanical and electrical engineering; licensed professional engineer and trades licenses in steam engineering, refrigeration, air conditioning, electrician, general building contractors, plumbing; thorough practical hospital experience. Apply MW 29, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

EXECUTIVE HOUSEKEEPER & LAUNDRY MANAGER—University graduate; Male; several years hospital experience; now on West Coast, consider any location United States and Foreign. Apply MW 45, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

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ASSISTANT ADMINISTRATOR — MHA, University of Minnesota; assistant administrator, 220-bed hospital, 2 years; administrator, small hospital, 2 years; nominee ACHA; early 30's.

EXECUTIVE HOUSEKEEPER—Male; early 50's; 2 years business college; 10 years full charge department, very large hospital unit; seeks similar opportunity; south preferred.

EXECUTIVE HOUSEKEEPER—Late 50's; college graduated; 4½ years assistant, large general hospital; seeks executive position, northeast or New England.

WOODWARD—Continued

MEDICAL RECORD LIBRARIAN—Consultant for several hospitals; available for position in Oklahoma, Texas or Arkansas; Member, American Association of M.R.L.'s; last position chief MRL, 475-bed, California hospital, four years.

PATHOLOGIST—Board Eligible, both branches; 3 years, medical officer, U.S. Army; 3 years, pathology residency, excellent 700-bed, university hospital; presently assistant professor; seeks post as associate pathologist, private hospital with facilities for research (teaching, if possible); numerous publications; middle 30's.

RADIOLOGIST—4 years, private general practice; completing 3 years, radiology residency, wonderful university hospital; seeks hospital post, south, southwest, or California; immediately available; Age 34.

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PURCHASING AGENT—Graduate eastern college auditing experience; 6 years purchasing agent, midwestern teaching hospital.

ASSISTANT ADMINISTRATOR—Age, 32 years; M.S.H.A. Degree; 3 years administrative assistant, and assistant director; prefers larger hospital.

ADMINISTRATOR—Age 35 years; Graduate eastern college; 3 years business manager, 120-bed hospital, North Carolina; 4 years administrator, 150-bed hospital, south; available.

(Continued on page 210)

INTERSTATE—Continued

PHARMACIST—Chief; present assistant director, department of pharmacy; prefers midwest or east.

EXECUTIVE HOUSEKEEPER—Age, 40; 6 months course; principles of housekeeping; supervisory experience, 250-bed hospital, 1956-1958.

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ADMINISTRATOR—Assistant; leading to administrator's position; 35-bed, progressive general hospital; M.S.H.A., or equivalent experience necessary; salary open. Address replies to Mr. H. Hughes, President, Capitol Hospital, 1971 West Capitol Drive, Milwaukee 6, Wisconsin.

DIVISIONAL ADMINISTRATOR — Outpatient, admitting, and X-ray nursing services, including service and education; salary upon request. Apply Director, Cook County School of Nursing, Department M, 1900 West Polk Street, Chicago 12, Illinois.

ANESTHETIST—R.N.A.; for nearly new 114-bed general hospital; hospital cafeteria, energetic medical staff; excellent starting salary with time and merit increases; liberal employee benefit program or free lance basis. Write Administrator, Coffeyville Memorial Hospital, Coffeyville, Kansas.

ANESTHESIA—Nurse; opening in surgery division; basic 40 hour week; salary to $550.00 monthly; overtime pay; liberal employee benefit program includes vacation, sick pay, and holidays. Write Personnel Department, St. Joseph Mercy Hospital, 900 Woodward Ave., Pontiac, Michigan.

ANESTHETIST—Nurse; to join Ob-Gyn anesthesia staff; 250-bed general hospital; 40 hour week, excellent salary, months vacation. Write Assistant Administrator, Highland Hospital, Rochester, New York.

ANESTHETIST—Registered; 130-bed modern hospital; college town, 20,000 population; salary open, plus full maintenance. Apply C. D. Ward, Administrator, Pitt County Memorial Hospital, Greenville, N. C.

ANESTHETIST—Nurse; come to wonderful western Pennsylvania; fully approved 194-bed community hospital, close to Pittsburgh. Write Administrator, Latrobe, Pennsylvania.

ANESTHETIST—Nurse; Texas Gulf Coast resort area; 250-bed general hospital with M.D.'s heading department; two vacancies; salary beginning $450 with increment increases. Reply Dr. R. J. Sigler, Memorial Hospital, Corpus Christi, Texas.

ANESTHETIST—Nurse; $400-$600 per month; excellent medical staff; 200-bed hospital; fringe benefits, health, life, retirement insurance, paid vacation-sick leave; hospital cafeteria, nurses' home accommodations. Contact E. J. Berg, Business Manager, Gundersen Clinic, La Crosse, Wisconsin.

ANESTHETIST—Nurse; RNA; to combine part-time anesthesia and assistant hospital administrator in 100-bed accredited hospital. Apply G. N. Wilcox Memorial Hospital, Lihue, Kauai, T. H.

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DIETITIAN—Opening in 400-bed hospital which is adding 120-bed rehabilitation unit; excellent opportunity in therapeutic or administrative work for A.D.A. registered person; salary commensurate with training and experience; liberal benefits. Apply Personnel Director, Iowa Methodist Hospital and Raymond Blank Memorial Hospital for Children, Des Moines, Iowa.

DIETITIAN—For 58-bed general hospital; to be in charge of kitchen and food service; desirable personnel policies and starting salary; located in a resort city on the shores of Lake Michigan. Write or call collect: Ralph W. Tarr, Administrator, Grand Haven Municipal Hospital, Grand Haven, Mich.

DIETITIANS—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries begin at $300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—A.D.A. or equal, full charge of department in 55-bed general hospital; modern kitchen, excellent conditions, salary open. Apply Administrator, Lakeview Memorial Hospital, Bath, New York.

DIETITIAN—Chief; A.D.A.; complete charge of food for 100-bed general hospital; JCAH approved; salary open. Apply Sacred Heart Hospital, Medford, Oregon.

DIETITIAN—A.D.A.; position open; 150-beds, new building and equipment; full charge of all food purchases, diets and personnel; position paying $5,000.00 or better depending on experience. Write to Administrator, Clearfield Hospital, Clearfield, Pennsylvania.

DIETITIAN—Assistant; attractive position in 150-bed established hospital, with new building and facilities, all services; excellent community near Philadelphia; top working conditions. Apply E. H. Prescott, Administrator, Pottstown Hospital, Pottstown, Pennsylvania.

DIRECTOR—Clinical; to head challenging training and research programs in 3000-bed state mental hospital; approved for 3 years residency training in psychiatry; eight room house available at nominal rate; retirement plan and many other excellent benefits; Salary $12,600 to $16,383, annual increments of $630; near N.Y.C. and Central Jersey shore area; requirements: Board Diplomate in Psychiatry and N. J. license. Apply: J. Berkeley Gordon, Medical Director, New Jersey State Hospital, Marlboro, New Jersey.

DIRECTOR—Medical records department; immediate opening; 446-bed general hospital; good salary and personnel policies; opportunity to work with professional activity study. Write Mr. J. M. Dunlop, Administrator, Bridgeport Hospital, Bridgeport, Connecticut.

DIRECTOR—Assistant; occupational therapy registered; modern tuberculosis hospital, with affiliation program; five day week, 40 hour, paid vacations, 7 holidays, sick leave, social security; excellent opportunity for progressive administrator. Resume to Director, Occupational Therapy, Emily P. Bissell Hospital, 3060 Newport Gap Pike, Wilmington 8, Delaware.

DIRECTOR OF NURSING SERVICE—Experience as head nurse or supervision preferred; 30-beds soon to move to new 50-bed hospital; reasonable vacation, sick leave, and fringe benefits; complete maintenance if desired; salary open; Eastern Kentucky near Lexington. Apply MO 242, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

DIRECTOR SCHOOL OF NURSING—For accredited diploma school; student body of 170; Masters degree required; 40 hour week; salary commensurate with qualifications; excellent personnel policies, social security, group hospitalization. Apply MO 246, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11 Illinois.

DIRECTOR OF NURSE EDUCATION—261-bed hospital, tuberculosis and other chronic diseases; southern Connecticut, affiliation student program; attractive salary, liberal personnel policies, social security and state retirement; degree with experience. Apply, Director of Nursing, Laurel Heights Hospital, Shelton, Connecticut, or State Personnel Director, Room 405, State Office Building, Hartford, Connecticut.

DIRECTOR SCHOOL OF NURSING—Three year diploma program; new modern hospital; 233-beds; must have B.S. in Nursing Education, preferably M.A. and successful experience; salary open, good personnel policies. Apply Executive Director, Memorial Hospital, Albany 4, New York.

DIRECTOR OF NURSING SERVICE AND EDUCATION—In accredited 500-bed hospital; diploma school with 200 students; affiliated in freshman year with Muhlenberg College; Master's degree and experience as assistant essential; starting salary commensurate with background and experience. Apply Assistant Superintendent, Allentown Hospital, Allentown, Pennsylvania.

INSTRUCTOR—Fundamentals of nursing; (nursing arts); salary range $420-$455 per month; 37½ hour week; single room, nurses residence; $20 and $25 per month. Apply Director, Cook County School of Nursing, Department M, 1900 West Polk Street, Chicago 12, Illinois.

INSTRUCTORS—Clinical; needed in the following categories: medical-surgical nursing, days; obstetrical nursing, afternoons; pediatric nursing, nights; integrated program; affiliated with Drake University; 200 students in school; 400-bed, fully approved, non-profit hospital; minimum qualifications: B.S. degree, preferably in nursing education; salary open; 40 hour work week; 20 working days vacation; sick benefits. Apply Director of Nursing, Iowa Methodist Hospital, Des Moines, Iowa.

INSTRUCTOR—Psychiatric nursing; progressive State Hospital with affiliate nursing program; starting salary dependent upon academic qualifications, experience and personal qualifications; starting range from $4140 to $8100 plus self-maintenance, liberal sick time, holidays, paid vacation. Write Dr. J. O. Cromwell, Superintendent, Mental Health Institute, Independence, Iowa.

(Continued on page 212)

LIBRARIAN—Chief registered medical records; 111 bed accredited hospital in San Diego County; good salary; future advancement; fringe benefits. Write, Administrator, P.O. Box 158, La Mesa, California.

LIBRARIAN—Medical record; registered; charge of 231-bed hospital; 40 hour week; salary commensurate with area. Apply Administrator, Providence Hospital, Oakland 9, California.

LIBRARIAN—Medical records; for 58-bed general hospital; to be in charge of the medical records library; desirable personnel policies and starting salary; located in a resort city on the shores of Lake Michigan. Write or call collect: Ralph W. Tarr, Administrator, Grand Haven Municipal Hospital, Grand Haven, Michigan.

LIBRARIAN—Registration or graduation from approved school and one year experience; to head department in 516-bed cancer research hospital; a challenging opportunity offering a starting salary of $5,424, two and one-half weeks vacation the first year, 40 hour week, and other attractive working conditions and benefits. Reply Personnel Director, Roswell Park Memorial Institute, Buffalo 3, New York.

LIBRARIAN—Registered; full charge of department in 72-bed hospital; located Oahu, Hawaii near Honolulu; salary open. Apply Personnel Director, Wahiawa General Hospital, Wahiawa, Hawaii.

LIBRARIAN—Medical record; 100-bed general hospital; good living and working conditions. Apply Administrator, G. N. Wilcox Memorial Hospital, Lihue, Kauai, T. H.

MISCELLANEOUS—Administrative Supervisors and Clinical Instructors (3); Instructor and Supervisor of non-professional personnel (1); for 165-bed Children's Hospital; affiliated program; 400 students a year; liberal personnel polices, salary based on experience and preparation; degree preferred. Apply MO 240, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

MISCELLANEOUS—Business manager; Nurse anesthetists; Night supervisor and night nurse; 60-bed hospital, medical surgical; salary commensurate with ability. Reply MO 241, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

MISCELLANEOUS—Nurse Supervisors (2); General Staff Nurses (3); immediate opening; 84-bed hospital located in lake resort area only 65 miles from Chicago; 5 day, 40 hour week; starting salary commensurate with experience and qualifications range to $350.00 for supervisors; for general duty staff nurse to $325.00, with periodic increases; free meal daily, four uniforms laundered weekly, sick leave to 21 days, vacation time to 21 days. Apply to L. H. Furlong, Administrator, Fairview Hospital, La Porte, Indiana.

MISCELLANEOUS—Nursing arts instructor, Clinical instructor, Evening nursing service supervisor; good personnel policies in modern hospital. Apply Mrs. Aileen L. Carroll, Director of Nursing, Buffalo General Hospital, Buffalo 3, New York.

MISCELLANEOUS—Operating room supervisor, Anesthetist and Scrub nurse—Newly opened 100-bed hospital, air-conditioned, recovery room, central supply and other modern conveniences; near residential and business section of town. Apply Beaufort County Hospital, Washington, North Carolina.

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NURSING MISCELLANEOUS—(a) Director Of Nursing; Administer and coordinate work of Nursing Service and School of Nursing; prefer masters degree in education or administration with successful experience. (b) Associate Director Of Nursing—in charge of School of Nursing; prefer masters degree in education but BS acceptable if accompanied by proven ability; JCAH accredited; non-sectarian hospital of 576-beds (including 125 non-acute beds) and NLN accredited, diploma school of 160 students; university affiliation for basic sciences; excellent salary, personnel policies and working conditions; furnished apartment at reasonable rent is available; City of 110,000 located in year round recreational area. Write Personnel Director, St. Luke's Hospital, Duluth 11, Minnesota.

NURSE—General duty; for small hospital in Alaska; some evening and night work; good salary, pleasant surroundings. Apply MO 244, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—General duty; 50-bed general hospital in beautiful valley of Virginia, about 2 hours from Washington D. C.; starting salary $265 evenings and nights, $250 days; scheduled increases, social security; Blue Cross available; single room lovely new mountain-view nurses home included; well equipped; JCAH accredited, comparatively new hospital. Write MO 245, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—General duty, operating room; salary $325 to $361 per month plus department premium of $10, shift premium of $20 extra per month; vacation up to 4 weeks, retirement program, social security, hospitalization insurance, 40 hour week. Apply Director of Nursing, Palo Alto Hospital, Palo Alto, California.

NURSES—Registered; for modern expanding 325-bed general hospital; all shifts available; liberal personnel policies; start at $325 per month, regular increments plus shift and service differentials. Apply Personnel Director, Mount Zion Hospital, 1600 Divisadero, San Francisco 15, California.

NURSES—Registered; for modern psychiatric hospital in Greens Farms, Connecticut; 1 hour from New York; Hall-Brooke nurses have 8-hour duty, optional 5 or 6 days week, nicely furnished private rooms; excellent salary, 7 paid holidays annually, or equivalent; sick leave; vacation, minimum 2 weeks, maximum 4 weeks dependent on length of service; profit-sharing plan; psychiatric experience not necessary; registered or eligible in State of Connecticut. Apply Mary R. Walsh, R.N., Directress of Nursing, Hall-Brooke, Box 31, Greens Farms, Connecticut. Tel. Westport—Capital 7-5105.

NURSES—Registered; 213-bed general hospital; liberal salary and personnel policies; all shifts and services available; progressive, hospitable city, 90 miles from seashore; ideal climate, adjacent military bases. Contact Director Nurses, Phoebe Putney Memorial Hospital, Albany, Georgia.

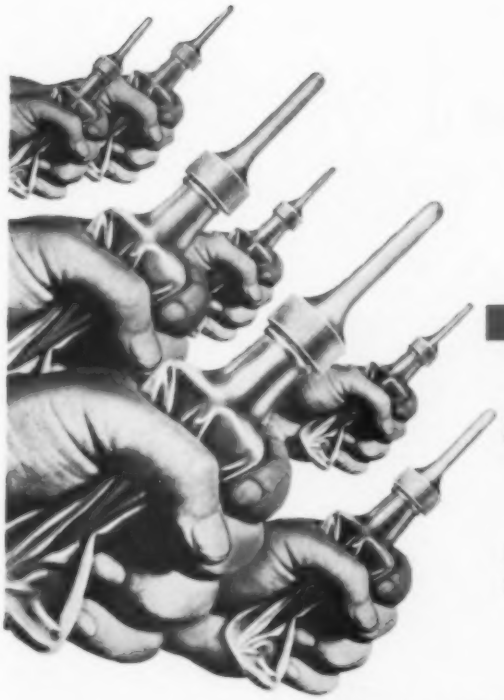
NURSES—Registered; immediate openings; starting salary $280 month with opportunity for advancement; room, board and laundry; annual vacation, liberal sick leave, 40 hour week. Apply Personnel Office, Mental Health Institute, Independence, Iowa.

NURSES—Registered; for 88-bed voluntary non-profit hospital in community of 11,000; basic salary $295 per month with increments of $5 every 6 months up to 2 years; 40 hour week; 7 paid holidays; sick leave accumulative to 36 days. Address inquiries to Director of Nurses, St. John's Hospital, Red Wing, Minnesota.

NURSE—Registered general duty; for 80-bed geriatrics home and infirmary; 3-11 shift, $325.00 monthly starting salary; good personnel policies. Reply Capitol District and Daughters of Sarah Jewish Home for the Aged, Troy, New York.

NURSES—General duty; 406-bed JCAH accredited hospital located in suburban Philadelphia; rotating shift or choice of 3-11 or 11-7 permanent shift; starting salary $265, bonus $20 for 3-11 shift; $10 for 11-7 shift. Contact Director of Nursing, Bryn Mawr Hospital, Bryn Mawr, Pennsylvania.

(Continued on page 214)



7 FLEET® ENEMA

Disposable Units *

may be administered in the time required for 1 soap suds enema.[1]

administrators like *FEDU

because FLEET ENEMA Disposable Units save time and money.[1]

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because the 4½ fl. oz. unit is more effective than one or two pints of soap suds,[2] and the anatomically correct rectal tube minimizes injury hazard.[3]

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because FLEET ENEMA Disposable Unit is ready to use, even to the pre-lubricated rectal tube. Eliminates preparation and "clean-up."

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because FLEET ENEMA'S combination of 16 Gm. Sodium Biphosphate and 6 Gm. Sodium Phosphate is gentle and the small amount of solution seldom causes pain or griping.

1. "Standard vs Disposable Unit Enema": Rainier, W. G.: and Lee, B., Hospitals 31:50, Jan. 1, 1957
2. Swinton, N. W., Surg. Clinics No. Am. 35:833, 1955
3. Palmer, E. D., "Clinical Enterology," Hoeber-Harper, 1957

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each single use disposable unit contains 127 cc. Mineral Oil USP.

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C. B. FLEET CO., INC., Lynchburg, Virginia

makers of Phospho-Soda (FLEET)

In Canada: Produced by Charles E. Frosst & Company

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NURSES—Registered; for 14-bed hospital in southeastern Alaska; starting salary $300 for 40 hour week. Write via airmail to Bishop Rowe Hospital, Wrangell, Alaska.

PHYSICAL THERAPIST—Prefer registered; 164-bed JCAH approved hospital; department requires re-organization, well equipped; salary open, good opportunity. Apply R. H. Athey, Newark Hospital, Newark, Ohio.

PURCHASING AGENT—Male for 250-bed general hospital with nursing school; college graduate, must have hospital purchasing experience; age 30 to 45; fine New England community near metropolitan area; salary open; please give complete background and minimum salary required. Apply MO 243, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSE SUPERVISOR—Operating room; 261-bed hospital, tuberculosis and other chronic diseases; southern Connecticut; administrative supervisor with operating room experience and preparation; attractive salary, liberal personnel policies, social security and state retirement. Apply, Director of Nursing, Laurel Heights Hospital, Shelton, Connecticut, or State Personnel Director, Room 405, State Office Building, Hartford, Connecticut.

SALESMAN—Wanted; if you are now or have been a detail man for a pharmaceutical company or a salesman for a surgical or hospital supply house, and are between the ages of 25-33 you may be the man we are seeking as an addition to the advertising sales staff of an outstanding professional magazine; in reply give details on educational background, service record, job experiences and as much additional data as possible. Reply MO 246, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

SUPERVISOR-INSTRUCTOR — Operating room; 209-bed general hospital; NLN fully accredited school of nursing; 96 students; 40 hour week; special clinical preparation in operating room supervision; salary open, liberal personnel policies. Apply Director of Nursing, Middlesex Memorial Hospital, Middletown, Connecticut.

SUPERVISING NURSE—To help plan, equip and operate a new and modern intensive care unit of 21-beds to be opened in the spring of 1959; position available at once; salary range between $345 to $410 depending on training and qualifications. Write, wire or call, collect, Director of Nursing, Samuel Merritt Hospital, Oakland, California. OLympic 5-4000.

SUPERVISOR—Obstetric; 406-bed JCAH accredited hospital, suburban Philadelphia; salary dependent upon qualifications; good personnel policies; position open. Contact Director of Nursing, Bryn Mawr Hospital, Bryn Mawr, Pennsylvania.

(Continued on page 216)

TECHNICIAN—Laboratory; 236-bed general hospital 30 miles from New York City; interesting position with advancement in progressive hospital. Contact Personnel Office, Morristown Memorial Hospital, Morristown, New Jersey.

TECHNICIAN—Laboratory, registered; top position open for male or female A.S.C.P. registrant. Write or phone Administrator, Canonsburg General Hospital, Canonsburg, Pennsylvania.

TECHNICIAN—Laboratory; 75-bed general hospital on sea coast 35 miles from Boston. Contact Personnel Office, Anna Jaques Hospital, Newburyport, Massachusetts.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 N. MICHIGAN AVENUE, CHICAGO

ADMINISTRATORS—(a) Medical; 500-bed general hospital, east; $25,000. (b) Assistant medical director, 450-bed general hospital; attractive city, outside United States. (c) Assistant director, 1000-bed hospital; preferably M.D. qualified direct outpatient clinic; opportunity succeeding director upon his retirement within few years; medical school city, midwest. (d) Assistant; Master's required,

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POSITIONS OPEN

MEDICAL BUREAU—Continued

preferably 30-40 with minimum three years' experience as assistant, large hospital or administrator, small hospital; 375-bed general hospital, California. (e) Assistant; Master's Hospital Administration; several years' experience required; 600-bed general hospital; east; $7-$10,000. (f) New 40-bed hospital; Mexico. (g) Small general hospital; preferably woman RN; minimum $5000 including penthouse apartment; midwest. MH11-1

ANESTHETISTS—(a) Handle complete anesthesia small hospital; prosperous farm community; $8000 up; midwest. (b) Staff; modern 200-bed hospital; Pacific Northwest; $6800. MH11-2

DIETITIANS—(a) Manage department, 50-bed modern hospital; Gulf region, Florida; good salary. (b) Teach in busy medical center; New York City area; $4800 plus MH11-3

DIRECTORS OF NURSING—(a) Director, male or female, 2,000-bed psychiatric hospital; to $9000, maintenance; midwest. (b) Director, nursing service and school; 180-bed hospital; progressive city, south; $8000-$10,000. (c) Director; all graduate staff; large specialty hospital commuting distance New York City; outstanding financial opportunity; prefer graduate hospital administration course. MH-11-4

EXECUTIVE HOUSEKEEPER—Wealthy suburban home for retired businessmen; also act as assistant administrator; midwest. MH11-5

EXECUTIVE PERSONNEL—(a) Controller; hospital group. 600-beds; university city, midwest; up to $10,000. (b) Personnel and purchasing; group of 62 hospitals; $8-$10,000 respectively; medical center, east. (c) Public relations director; capable of conducting in-service training program; 250-bed general hospital near New York City. (d) Personnel director; 500-bed general hospital; university city, Pacific Coast. (e) Assistant purchasing director; 1000-bed teaching hospital, east. (f) Food director; 550-bed hospital; near Philadelphia. MH11-6

FACULTY—(a) Educational director; establish in-service program; prepare procedure manual; ideal Florida location; top salary. (b) Instructors; adult vocational schools; $6600 up; midwest. MH11-7

RECORD LIBRARIANS—(a) Organize new record installation of Southern California medical center; above average salary. (b) Small friendly Arizona health resort; 40-bed hospital; $400 start. MH11-8

(Continued on page 218)

MEDICAL BUREAU—Continued

SUPERVISORS—(a) Outpatient; renowned hospital outside United States English speaking personnel; mild ocean climate; $5000 up, transportation. (b) Operating room, central service, act as consultants in hospital planning; travel thruout United States; $7500 expenses. MH11-9

ADMINISTRATORS—(a) Group, 3 fully-approved hospitals, totaling 425-beds; $15,000; New England. (b) Direct 60-bed hospital and act as consultant, 4 additional small hospitals; direct each hospital as they open; Southern California. (c) Medical or non-medical; 400-bed, university hospital, unit of important university medical center; warm climate; substantial. (d) New hospital, 150-beds, serving clinic staffed by 50 men; tropical island, American dependency; $12-15,000. (e) 700-bed, general hospital, fully-approved; sub-

classified advertising

POSITIONS OPEN

WOODWARD—Continued

stantial; city 120,000, east-north-central. (f) Very large, general hospital, affiliated 3 important medical schools; report direct to medical director, whose primary functions are professional aspects of operation; will have two assistants; about $13,000, possibly more; east. (g) 110-bed, new hospital; large, medical school city on Great Lake. (h) 240-bed, JCAH, voluntary, general hospital; city, 100,000, California. (i) Planning beautiful, resort-area, 125-bed hospital; urgently need that he may advise planning; South Atlantic.

ASSISTANT ADMINISTRATORS—(j) 225-bed, voluntary, general, fully-approved hospital; about $8,000; large city, midwest. (k) 200-bed, general, voluntary, JCAH hospital; to $6,000; college town, midwest. (l) 600-bed, fully-approved hospital; $7-10,000; east.

ADMINISTRATIVE POSTS—(m) Business manager; civil service post; requires accounting and administration courses, degree; & 6 years experience, Public Health Administration; $9,000; midwest. (n) Credit manager; new post; assist business manager; 30 man clinic group; own 3 clinic buildings; $4,800-$6,000; excellent opportunity advance; university city, mideast.

WOODWARD—Continued

EXECUTIVE HOUSEKEEPERS—(a) Full charge department, 350-bed general hospital and 3 residences; prominent institution offering challenging opportunity qualified individual; midwestern university, capital city. (b) Approved 250-bed general hospital, affiliated large clinic; to $5,000; full maintenance available single woman, married with small family; eastern resort community. (c) General hospital 200-beds, approved; popular Florida resort location. (d) Now expanding to 100-beds; newly created position; friendly midwestern town 15,000. (e) 100-bed approved general hospital, opened late 1955; excellent facilities, equipment; southwestern resort community 35,000.

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

ADMINISTRATORS—(a) 1200-bed general hospital; will have two assistants; $13,000. (MH-2367) (b) Middle west; 50-bed hospital; air-conditioned; opened April 1956; $6,000 minimum. (MH-2318). (c) East; 100-bed hospital; prefer Masters degree in hospital administration. (MH-1852). (d) South; 50-bed

(Continued on page 220)

SHAY—Continued

hospital; $8000. (MH-2436). (e) East; 115-bed hospital in industrial community. $8400. (MH-2396). (f) East; 60-bed hospital $6500. (MH-2397).

EXECUTIVE PERSONNEL—(a) Business manager; southwest; Degree in accounting or business administration; large hospital; $8400 plus lovely home on hospital grounds. (MH-2462). (b) Personnel director; middle west; 275-bed hospital; 600 employes; $7200. (MH-2346) (c) Assistant business manager; southeast; 500-bed hospital. (MH-2434). (d) Credit and collection manager; south resort area; 50-bed hospital, new. (MH-2357). (e) Personnel director; southwest; 500-bed teaching hospital (MH-2195). (f) Purchasing agent; east; 500-bed hospital. (MH-2229). (g) Accountant office manager; 100-bed hospital; east; 60-bed expansion planned. (MH-2226).

INTERSTATE MEDICAL PERSONNEL BUREAU
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332 Bulkley Building
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ADMINISTRATOR—(a) 55-bed hospital, Pennsylvania. (b) 45-bed hospital, Illinois. (c) R.N. (male or female); small psychiatric institution, midwest.

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The Man with the Lily Plan knows hospitals are short of help and money. Here are 6 Lily ways to save you both:

1. *Serve in dispensable Lily Place settings* . . . economical, easy for patients and staff to handle. Cups and containers for every food and beverage—hot or cold. Lily* plastic-coated, decorated plates (top) in 5 convenient sizes: from 6" to 9⅝". Strong, waterproof molded plates keep foods separated, keep juices confined, aid portion control. Compartmented 9¼" (a Lily exclusive) and 10¼" sizes; non-compartmented: 6, 9¼ and 10 in. sizes.

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Alfred E. Riley, R.N., MSHA Director

INTERSTATE—Continued

PURCHASING AGENT—Large new hospital; west.

PERSONNEL DIRECTOR—(a) 300-bed hospital, Ohio. (b) 400-bed hospital, Pennsylvania.

COMPTROLLER—(a) 600-bed hospital, industrial city, midwest. (b) Chief accountant; 400-bed hospital, south. (c) Accountant, tuberculosis hospital, east. (d) Office manager, 100-bed hospital, Pennsylvania.

DIRECTOR OF NURSING—(a) 275-bed hospital, New England; $8,000. (b) 400-bed hospital, Ohio. (c) Directors, Nursing service; to $7,000.

TECHNICIAN—(a) Chief X-ray; 160-bed Ohio hospital (b) Laboratory technicians; to $450.

EXECUTIVE HOUSEKEEPERS—(a) 300-bed hospital, Massachusetts; (b) 450-bed hospital, south. (c) 140-bed hospitals, Ohio, Indiana, Pennsylvania, New Jersey, Michigan, Texas.

ADMINISTRATORS—(a) 125-bed Ohio, JACH hospital; new; salary open. (b) 60-bed hospital, Pennsylvania; salary $7,200. (c) 60-bed hospital, Tennessee; salary $7,200. (d) 70-bed hospital, Tennessee; salary $8,500. (e) 150-bed university hospital; must have degree plus university experience; southern resort area; salary open; excellent opportunity. (f) 30-bed hospital, Wyoming; salary open. (g) 60-bed hospital, Nebraska; salary $6,000. (h) 1500-bed County hospital; M.D. or well experienced administrator; north; salary open.

ASSISTANT ADMINISTRATORS—(a) 200-bed hospital, Massachusetts; salary open. (b) 300-bed hospital, Michigan; Sisters hospital; degree plus experience in Business Management; salary open. (c) Assistant administrator in charge of personnel and other duties; salary open; Sisters hospital, Massachusetts. (d) Assistant administrator; charge of personnel and public relations, Sisters hospital, Wisconsin; 150-bed hospital.

BUSINESS MANAGERS AND COMPTROLLERS—(a) 500-bed hospital, Michigan; must have budgeting experience; salary to $10,000. (b) 300-bed Sisters hospital, Michigan; salary open; must have degree plus 5 years experience. (c) 300-bed hospital; Chicago; salary open. (d) 400-bed hospital, Rhode Island; must be experienced comptroller; salary to $9,500.

MEDICAL EMPLOYMENT—Continued

PERSONNEL DIRECTORS—(a) 400-bed hospital; Ohio; salary $6,500 and up. (b) Sisters hospital; 300-beds, Michigan; salary to $7,200. (c) Wisconsin; Sisters hospital; 300-beds; salary to $7,200. (d) 300-bed Sisters hospital, Connecticut; salary open; new department.

PURCHASING AGENTS—(a) 300-bed Sisters hospital; new department, full control, Mass.; salary open. (b) 275-bed Sisters hospital, Rhode Island; salary open. (c) Combination pharmacist and purchasing agent, Chicago; 80-bed hospital; salary to $7,200; new hospital.

ADMINISTRATIVE ASSISTANTS—(a) Male or female RN, with MS degree in Hospital Administration or Nursing Administration; to take charge of a 450-bed Sisters hospital, Michigan; salary open; will carry administrative assistant title. (b) 450-bed hospital; male or female; MS degree required same as above; salary to $9,000. (c) University Teaching Hospital, full charge of nursing department; male or female; degree required; salary open. (d) 500-bed new Protestant hospital, Kentucky; salary to $9,000; M.S. degree and experience required.

COMBINATION X-RAY & LABORATORY TECHNICIANS—(a) Female, chief for a 65-bed Texas hospital; salary to $500

(Continued on page 222)

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Gold Bond Travacoustic ceilings keep the noise level down, and do it attractively, too. Your bed-bound patients will appreciate the dozens of handsome designs that can be made with combinations of Sculptured Travacoustic tiles.

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BUILDING PRODUCTS

NATIONAL GYPSUM COMPANY

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POSITIONS OPEN

MEDICAL EMPLOYMENT—Continued

per month. (b) 55-bed hospital Nebraska; female; salary to $450 plus call time. (c) Male, to take charge of a 20-bed hospital as administrator and laboratory & X-ray technician; salary to $600. (d) Illinois 60-bed hospital, near Chicago; salary $500 per month. (e) 100-bed hospital, Chicago; salary $450 per month.

ASCP LABORATORY TECHNICIANS—(a) Chief laboratory technician; male or female; B.S. or M.S. degree required; 300-bed hospital; salary $600 per month; 40 hour week. (b) 100-bed hospital; Illinois; salary $425, plus call one night per week with extra pay for all calls. (c) Tissue technician, Illinois; 300-bed Sisters hospital; salary open; commission fee paid. (d) 100-bed Ohio; salary $450 plus commission fee paid; overtime for calls; 3 other technicians in hospital.

BIO-CHEMISTS & BACTERIOLOGISTS—(a) MS level; charge of departments; Illinois, near Chicago; salary to $600. (b) Chicago University center; salary open. (c) Texas; teaching center; salary to $650.

PHARMACISTS—(a) Chief; large 400-bed Sisters hospital, Michigan; salary open. (b) 300-bed hospital; Ohio; salary open. (c) 1400-bed State hospital, Ohio; salary $500 per month; increases every six months.

MEDICAL EMPLOYMENT—Continued

NURSE ANESTHETISTS—(a) Male; 100-bed Mississippi hospital, near Coast and New Orleans; salary $600 per month. (b) 100-bed hospital, Florida, salary $500; resort area. (c) Ohio; 200-bed hospital; $500, plus overtime; commission fee paid; male or female. (d) 50-bed hospital, Arizona; salary $550; resort area. (e) Michigan; 300-bed Sisters hospital; salary open.

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(Continued on page 224)

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MARY A. JOHNSON ASSOCIATES
11 West 42 Street New York 36, N.Y.
Mary A. Johnson, Ph.D., Director

FINE SCREENING BRINGS BEST RESULTS Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven methods shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

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Psychiatric Nurse—Prefer B.S. in Nursing; will accept Psychiatric Nursing experience, supervisory experience required. SALARY from $4296

Nursing Instructor—Prefer B.S. in Nursing with Psychiatric Nursing experience. SALARY from $4296

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(Continued on page 226)

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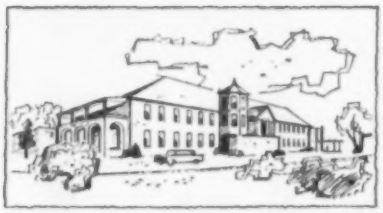

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Tryon, North Carolina
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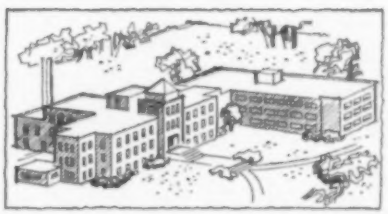
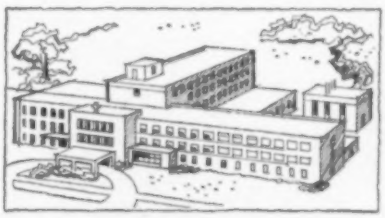
Pledged: $209,000

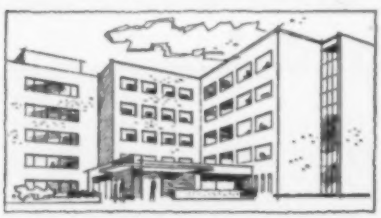


BUCYRUS
COMMUNITY HOSPITAL
Bucyrus, Ohio
Goal: $650,000
Pledged: $853,000

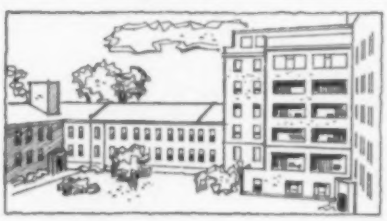
STOUDER
MEMORIAL HOSPITAL
Troy, Ohio
Goal: $300,000
Pledged: $335,000



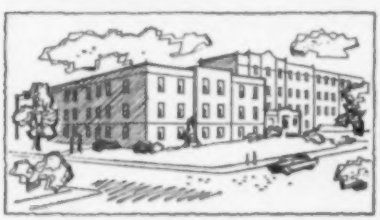
ST. JOSEPH'S
HOSPITAL
Lorain, Ohio
Goal: $1,610,000
Pledged: $1,689,000



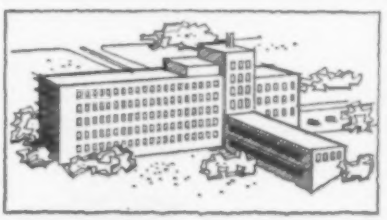
FRAMINGHAM
UNION HOSPITAL
Framingham,
Massachusetts
Goal: $900,000
Pledged: $948,000



ST. JOSEPH'S
HOSPITAL
Elmira, New York
Goal: $1,000,000
Pledged: $1,002,000



MARIETTA
MEMORIAL HOSPITAL
Marietta, Ohio
Goal: $700,000
Pledged: $737,000



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SCHOOLS—SPECIAL INSTRUCTION

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

UNIVERSITY OF MICHIGAN School for Nurse Anesthetists offers a 16 month course for nurses interested in anesthesia. Accredited by the American Association of Nurse Anesthetists. The training includes all technique in inhalation, intravenous, and rectal anesthesia. Unlimited opportunities for endotracheal intubation and open chest anesthesia. Stipend provided. For information write School for Nurse Anesthetists, University Hospital, Ann Arbor, Michigan.

SCHOOL—SPECIAL INSTRUCTION

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

THE GRADUATE HOSPITAL
University of Pennsylvania
PRACTICAL NURSING SCHOOL
(State accredited)
Offers a one year hospital course for women 18 to 45 years of age. For particulars write:
Director of Nursing
Graduate Hospital
19th & Lombard Sts.
Philadelphia 46, Pa.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Missouri.

FEATURES here

here

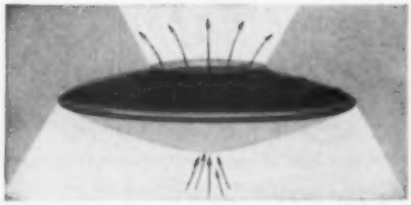
here

here

...and many more...
explain why
everyone approves
these new

DAZOR LAMPS

with Fiber Glass Diffusers



Dazor Lamps at top of page are Swing-Arm Pedestal Model 2005 and Table and Desk Model 2003. Just above is Swing-Arm Desk and Table Model 2004. Standard finish is frost-green baked enamel over bonderizing, combined with brass. Optional colors at no extra charge: frost-tan, statuary-bronze, gray or ebony. Lamps with color-matching arms are also available.

The extra lighting convenience, glare-free seeing comfort and distinctive styling of these new matched Dazor Lamps are enjoyed by patients, visitors, staff. They embody the latest lighting concepts. Broad, direct illumination is softened by a fiber glass diffuser. An opening in the bottom emits an undiffused light beam on the reading or writing surface and also admits air for natural ventilation. Each user controls light location and intensity in Swing-Arm models by adjustment horizontally, up or down or at an angle.

Air Cooling... Upper-Level Lighting

A perforated metal ventilator in the reflector top permits rising air to carry bulb heat away for cooler lighting and safe handling. The same perforations release partial upward light which tends to minimize abrupt brightness contrast, thereby reducing eye fatigue. Choose from varied decorator finishes for patient rooms, lounges, offices, nurses' dormitories. Authorized Dazor Distributors and their Dealers will gladly provide details and prices. Investigate now. Dazor Manufacturing Corp., 4481-99 Duncan Ave., St. Louis 10, Mo. In Canada, Amalgamated Electric Corporation Ltd., Toronto 6, Ontario.

ONLY QUALITY FIXTURES COME FROM
THE MAKERS OF

DAZOR FLOATING LAMPS

FLUORESCENT and INCANDESCENT

For additional information, use postcard facing Cover 3. 227

Crane hospital plumbing fixtures were designed for your hospital

The scrub-up sink that doctors helped design. *The Mayo permits scrubbing up to the shoulder without touching the fixture. It's made of Crane Duraclay—an exclusive smooth ceramic—won't crack, craze, or stain.*

Remote control is more than convenient. *Many Crane fixtures are equipped with foot-operated valves (or knee valves as in the Mayo above) that eliminate faucet handles as a means of germ transmission.*

Today's modern hospitals require a wide variety of specialized hospital fixtures . . . fixtures especially designed by medical and hospital authorities for specific use.

That's why the Crane line was developed with the help of doctors, technicians, administrators, architects and engineers, with your specific needs in mind.

One of the results of this cooperative effort was *Crane Duraclay*—a special all-ceramic material. Duraclay was developed for large fixtures, especially those subject to extreme thermal shock and vigorous cleaning. Its smooth, heavily glazed surface won't crack or craze. It resists acids, staining, and pitting. So it can be kept spotless (and aseptic) easily—for years.

Crane design embraces many other features that help fight cross-infection—such as foot- and knee-operated valves that furnish water without hand contact. Why not discuss this with your architect before you build or remodel?

CRANE CO. 836 S. Michigan Ave., Chicago 5 • VALVES • FITTINGS • PIPE • PLUMBING • KITCHENS • HEATING • AIR CONDITIONING

CRANE THE PREFERRED PLUMBING

Edited by BESSIE COVERT

WHAT'S NEW

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form on page 271. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

DON'T STOP HERE! *"What's New" continues intermittently through page 270*

Every Item Clearly Visible on Samaritan Dressing Cart

Two top shelves of Plexiglas make every item clearly visible on the new Models

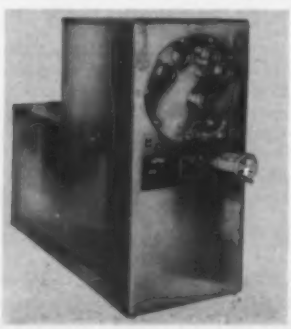
D-1 and D-2 Dressing Carts introduced by Samaritan. The carts have aluminum frames for lightness with strength and move easily on eight-inch silent rubber-tired casters. Model D-1 pictured is equipped with solution bottles, a Plexiglas box for small items, sections for small items and non-marking rubber-type corner bumpers. **Samaritan Cart Co., Inc., 2320 Sycamore Rd., York, Pa.**

For more details circle #921 on mailing card.

Tomac Shelf Truck Facilitates Handling of Supplies

The new Tomac Shelf Truck provides a mobile supply system which permits the storing of all supplies at one central despatch center. Each loaded truck becomes a supply cabinet on wheels which remains in one area until exchanged for a freshly loaded truck. Supplies are always available at the truck, simplifying inventory and freeing other storage space.

The new shelf truck can be adapted to fit any hospital procedures. Shelves, shelf dividers, drawers, tote boxes, gates and



bag hooks are added to convert for sterile supply, housekeeping, I.V. or any other special requirement. **American Hospital Supply Corp., Evanston, Ill.**

For more details circle #922 on mailing card.

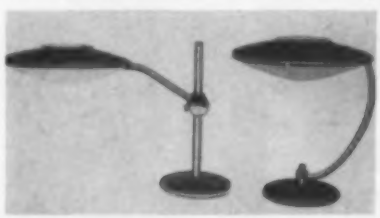
Disposable Tissue Towel in Larger size

Developed in an adequate size for hospital and other medical uses, the new disposable Sanek Super Towel measures 25 by 14 inches. Retaining the Sanek towel features of strong wet strength, high absorbency and softness, the new Super Towel is available in white with edge embossing. It is bulk-packed 500 to the case. The standard-size Sanek Towel measuring 20 by 12 inches in size will continue to be available. **Kimberly-Clark Corp., Neenah, Wis.**

For more details circle #923 on mailing card.

Desk and Table Lamps in Several Styles

Two new matching desk lamps for offices, patients' rooms, lounges and personnel housing are added to the Dazor line. Both lamps employ fiber glass diffusers to soften direct illumination in the seeing



area, with a partial upward light to eliminate brightness contrast between the lamp and its background. The incandescent lamps have air cooled design to prevent the possibility of burns from the reflector. Table and Desk Model 2003 has a stationary light while Model 2004 is a Swing Arm Lamp permitting the positioning of the light to the desired area. The lamps are offered in a variety of pleasing finishes. **Dazor Mfg. Corp., 4483 Duncan Ave., St. Louis 10, Mo.**

For more details circle #924 on mailing card.

Monovue Illuminator Is Radiographic Film Viewer

Designed for viewing of all x-ray film up to 14 by 17 inches in size, wet or dry, the new Monovue Illuminator weighs only nine pounds. The viewing panel of Plexiglas is one-eighth inch in thickness. The brightness of the center of the viewing surface exceeds 400 foot-lamberts when operated at rated voltages, and there are no appreciable variations in brightness throughout the surface.

The radiograph is held firmly in the film viewer by a steel film retainer across the top. Insertion and removal are facilitated without scratching the emulsion. A microswitch under the film retainer turns on the illuminator when the film is inserted for automatic single film viewing

and the light source is controlled manually by a button on the film retainer for continuous viewing. Hanger brackets and drip tray are provided for wet-film viewing. The Monovue Illuminator is suitable for desk, wall, in-the-wall or group mounting. **Westinghouse Electric Corp., X-Ray Dept., P. O. Box 416, Baltimore 3, Md.**

For more details circle #925 on mailing card.

Basic Research Apparatus for Large Quantity Cultures

Biogen is the name given a new basic research apparatus designed to enable the hospital to carry on wider ranges of experimentation with microbial cells. It was developed as a result of the increased demand for a continuous supply of certain substances such as enzymes, proteins and the like for use by researchers to investigate fundamental properties of the microbial cell itself. It is designed to culture large quantities of bacteria, yeasts, molds and other microorganisms.

The instrument consists of a double-walled cylindrical, stainless steel chamber which houses a rotating agitator with aer-

ation fins. Complete controls governing sterilization, agitator speed and other action are located on the front of the stainless steel cabinet. **American Sterilizer Co., Erie, Pa.**

For more details circle #926 on mailing card.

(Continued on page 232)

Electrically Controlled Door Has Safety Features

No springs are used in the new Rixson electrically controlled door operator which employs hydraulic power both to open and to close the door. The door operator is center hung and completely concealed in the floor. It can be actuated by mat, button switch or overhead chain switch. A dry-sump system avoids possible floor damage by fluid leakage. The operator is designed for foolproof public use, with completely automatic electrical controls.

A safety trip stops the door when a person steps on the safety mat, preventing the danger of being struck by a door in its opening swing. The door will not swing suddenly open should a person walk off the safety mat, then step back while the door is closing. The safety control also trips and stops the motor if the door's opening or closing swing is blocked in any way, thus preventing motor burn-out. **The Oscar C. Rixson Co., 9100 W. Belmont Ave., Franklin Park, Ill.**

For more details circle #927 on mailing card.

Sheets Do Not Slide on Improved Gatch Mattress

Re-molded polyurethane is used to form the new Syko-ette Mattress No. 1000. The re-molding gives the mattress full elasticity and, together with the new outer finish, it produces a smooth, firm mattress giving orthopedic-type support, yet conforming to all positions of Gatch beds. The finish holds the bed sheets from sliding and is impermeable, thus protective sheeting is not needed.

The low-cost mattress does not produce heat, thus reducing the possibility of bed

sores. It is fully washable, non-staining, odorless and does not hold odors. It is impervious to body fluids and wastes and is light and easy to handle. The single seam is sealed to prevent collection of bacteria. **The Balyeat Co., 481 N. Main, Mansfield, Ohio.**

For more details circle #928 on mailing card.

Texture-Chip Design in Vinyl-Asbestos Flooring

The Imperial series in Excelon Tile has a texture-chip design that extends entirely through the thickness of the vinyl-asbestos flooring. No amount of traffic or other wear can remove the non-directional graining design in the new flooring. Eight patterns are available in the new styling, each pattern having various tones of the basic coloring scattered through the flooring. The new tile is constructed to withstand the effects of spilled materials and resists grease, alkali and dilute acids, making it suitable for use even in laboratories, kitchens and dining areas. **Armstrong Cork Co., Lancaster, Pa.**

For more details circle #929 on mailing card.

Gold Seal Tile Products Have "Featherveined" Color

A controlled, constant decoration that goes all the way through Gold Seal asphalt

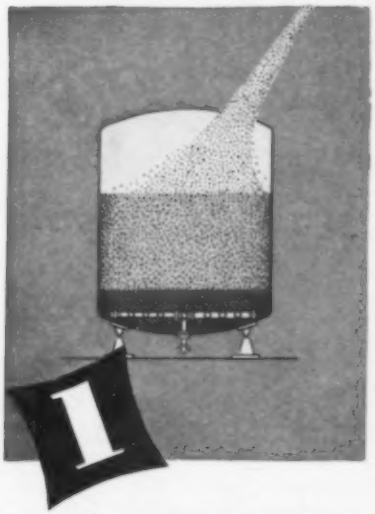
and vinyl asbestos tile is the result of a new manufacturing process. Known as "Featherveining," the new electronically controlled production assures precision and uniformity in size, color, texture, gauge and strength. The new color lines, with "Featherveining Thru and Thru," are available in Gold Seal Asphalt Tile and Gold Seal Vinylbest tile.

New to the line for institutional use is Vinylbest with ⅛ inch color line available in 15 colors, including clear neutrals and decorator tones. The illustration pictures a test indicating uniformity of color and decoration throughout the flooring, eliminating the possibility of pattern wear in heavy traffic areas. **Gold Seal Div., Congoleum-Nairn, 195 Belgrove Drive, Kearny, N.J.**

For more details circle #930 on mailing card.

(Continued on page 234)

Three Ways to Get MORE SOFT WATER



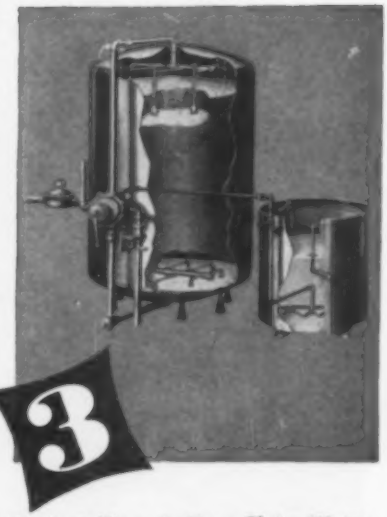
By Refilling Your Water Softener With New High Capacity Elgin Zeolite you can get 3 to 10 times more soft water.

Think of it, from 3 to 10 times more soft water from your present water softener by simply refilling it with one of Elgin's new high capacity zeolites. Here is a dividend-paying investment you can't afford to pass up. In addition, regeneration will be required less frequently with savings in regeneration time and salt costs.

Replacement of lost or worn-out zeolite also will provide increased soft water output. All types of zeolite are available for immediate delivery.

By Equipping Your Water Softener With An Elgin "Double-Check" Manifold System which permits the use of a deeper zeolite bed to further increase capacity as much as 44%.

The ingenious Elgin "Double-Check" manifold system makes it possible to place far more zeolite in a water softener and to utilize it more efficiently. Capacity increases of as much as 44% can be secured. Loss of costly zeolite will be prevented too. Higher brining and backwashing efficiencies will be obtained. Here is another low cost answer to the need for more soft water.



By Installing A New Elgin Water Softener of "Double-Check" Design which gives up to 44% more soft water than softeners of conventional design.

Where new equipment is required, here is today's outstanding buy. Size for size, the Elgin Water Softener of "Double-Check" design delivers up to 44% more capacity than water softeners of conventional design. This big increase is due to the ingenious "Double-Check" manifold system of the Elgin which permits far more zeolite to be placed in the softener without zeolite loss. Get the facts about this amazing water softener before you buy.

. . . and some added Elgin Services for Hospitals . . .

ELGIN DEALKALIZERS prevent corrosion of steam and condensate lines the basic economical way. Savings in piping, repairs and chemical treatment expense pays Dealkalizer cost many times over.

ELGIN DEIONIZERS produce mineral free water to replace distillation at a fraction of distillation cost.

ELGIN DEAERATING HEATERS supply preheated boiler water free of trouble-causing CO_2 and oxygen . . . pay real dividends on investment.

ELGIN SOFTENER CORPORATION • 144 North Grove Avenue, Elgin, Illinois

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SINCE 1908

In Canada:
G. F. Sterne & Sons
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Coupon brings facts for services checked—

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- ☐ Modernizing present water softener
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- ☐ Facts about Elgin Dealkalizers
- ☐ Facts about Elgin Deionizers
- ☐ Facts about Deaerating Heaters

HOSPITAL_____

ADDRESS_____

CITY_____ ZONE ____ STATE_____

SIGNED_____ TITLE_____

Mail to Elgin Water Softener Corporation, 144 N. Grove Avenue, Elgin, Illinois

For additional information, use postcard facing Cover 3.

White, Flexible Drinking Straws Bend in Any Direction

Glasco Products introduces a new crisp, white, flexible drinking straw designed especially for hospital use. The new straws

bend in any direction for constriction-free administration of hot or cold liquids. They are made of sturdy paper, clinically wax coated to ensure resistance to normal extremes of temperature. The straws are available wrapped in bactericidal paper and packaged in a sanitary contamination-proof box; and unwrapped, packaged in a dispenser box. Economical, convenient and disposable, the straws are designed for use by both patients and personnel and are sold only through hospital and surgical supply dealers. **Glasco Products Co., 111 N. Canal St., Chicago 6.**

For more details circle #931 on mailing card.

Gray Sheet Glass for Brightness Control

Pennvernon Graylite is the name given to a new gray sheet glass for building areas which require brightness control. Manufactured in ⅛ and 7/32-inch thicknesses, Graylite is formed to reduce the need for supplementary light control measures and is recommended by the manufacturer for glazing elevations facing east, southeast, west, southwest and points between, especially when subject to direct sunlight exposure. It is also advantageous for use in ribbon windows and ventilator units in conjunction with light-directing glass block. Graylite permits adequate visibility of the exterior, yet provides a degree of daytime privacy since it is easier to see through it to the outside than to see from the outside in. **Pittsburgh Plate Glass Co., 632 Fort Duquesne Blvd., Pittsburgh 22, Pa.**

For more details circle #932 on mailing card.

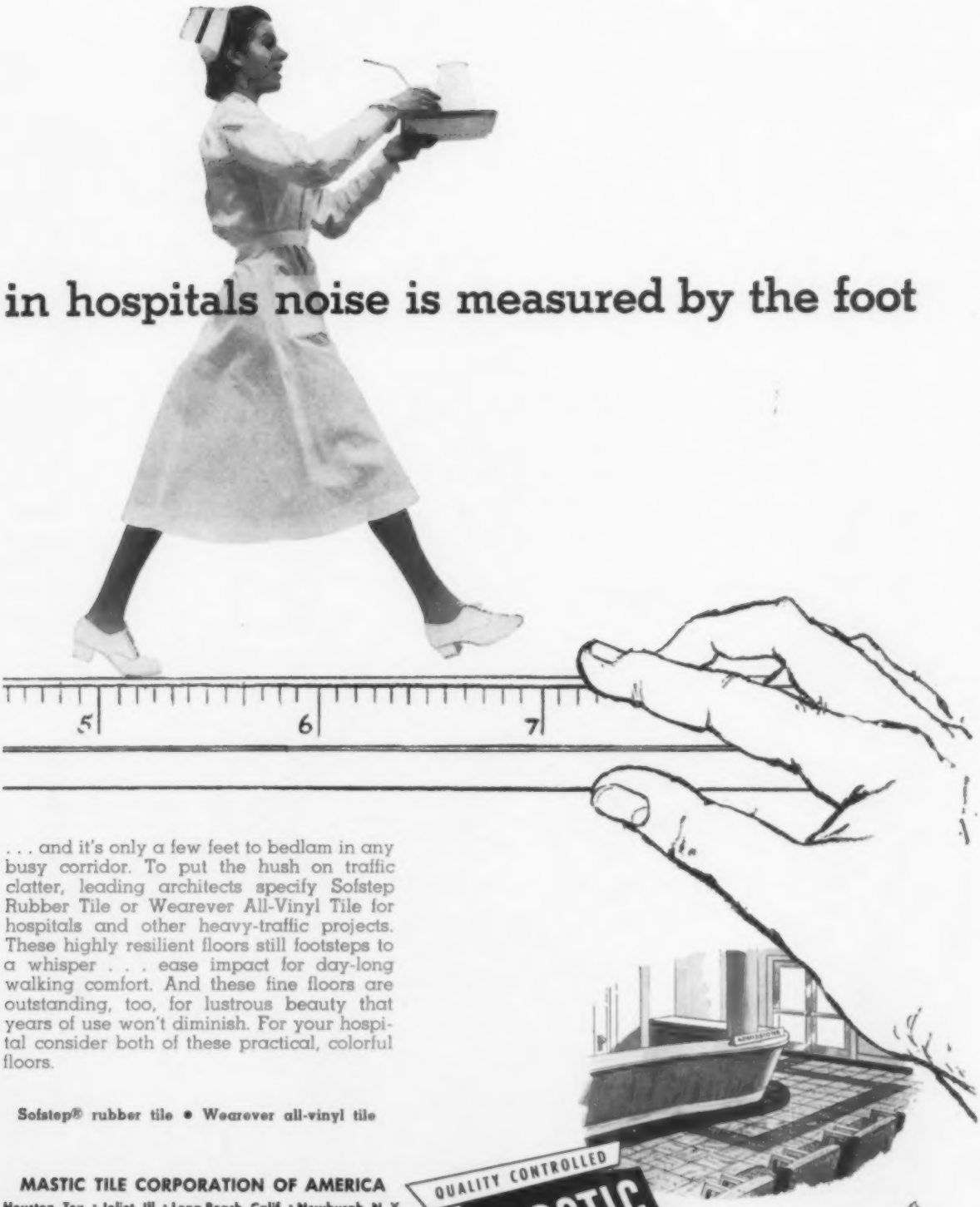
Plastic Catheter for I.V. Adds to Patient Safety and Comfort

The Deseret Intracath is a sterile-pack disposable unit which places a soft, pliant, vinyl plastic catheter within the vein for intravenous infusion. Nursing time is considerably reduced and patient comfort is increased as no arm board is necessary and the patient can move about without danger of interrupted intravenous medication or other complications. No scrubbing or gloving of the hand is necessary for inserting the catheter and only one veni-puncture is necessary when the Intracath is used.

A fully disposable unit, the Deseret Intracath comes in a heat-sealed transparent, sterile cellophane package. It is inexpensive to use, clean, smooth functioning, convenient and non-pyrogenic. **Deseret Pharmaceutical Co., Inc., 20 E. Stratford Ave., Salt Lake City, Utah.**

For more details circle #933 on mailing card.

(Continued on page 240)



in hospitals noise is measured by the foot

. . . and it's only a few feet to bedlam in any busy corridor. To put the hush on traffic clatter, leading architects specify Sofstep Rubber Tile or Wearever All-Vinyl Tile for hospitals and other heavy-traffic projects. These highly resilient floors still footsteps to a whisper . . . ease impact for day-long walking comfort. And these fine floors are outstanding, too, for lustrous beauty that years of use won't diminish. For your hospital consider both of these practical, colorful floors.

Sofstep® rubber tile • Wearever all-vinyl tile

MASTIC TILE CORPORATION OF AMERICA

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Please send me free samples and full details about Sofstep Rubber and Wearever All-Vinyl Tile.

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Non-Adherent Dressing Offered in Sterile Pack

Owens Surgical Fabric, a non-adherent rayon contact dressing recently introduced, is now available in a new sterile pack. The close weave of the rayon dressing prevents invasion of the capillary buds and consequent painful adhesion to the wound, yet it permits drainage through the mesh. The dressing can be applied to burns, granulating areas, skin graft sites and surface wounds. It can be sterilized by autoclaving but comes in a double-wrap package that facilitates aseptic handling. It is available in three by eight-inch dressings in individual envelopes, three dozen to a box, and in eight by 12-inch dressings, one dozen to a box. Owens Surgical Fabric is also available in a non-sterile roll of ten square yards, 41 inches wide. **Surgical Products Div., American Cyanamid Co., Danbury, Conn.**

For more details circle #934 on mailing card.

Nightingale Lamp Line for Residence Areas

A new line of Nightingale lamps is announced for use in nurses' homes and other housing facilities for staff or personnel. Model No. 319 illustrated is a desk or reading lamp which swivels horizontally and serves as a study lamp, reading lamp, and general indirect room illumination. The combined direct and indirect illumination makes it easy on the eyes. The economical "built-in" unit is easily installed and can be fastened to desk or other unit, minimizing the possibility of theft or breakage.

Other lamps in the new line include floor, table and wall models. They all feature a reflector with baked white enamel lining resting on a diffuser which combines

both direct and indirect illumination. **Adjustable Fixture Co., 110 E. Mason St., Milwaukee 2, Wis.**

For more details circle #935 on mailing card.

Vinyl Flooring Tile Resists Flames

A new flooring material that does not support combustion and which resisted the direct flames of a blowtorch in special tests is introduced by Goodrich. The fire-retardant Koroseal Vinyl Tile is inherently stable, does not rot, curl, flake or crack and is mildewproof and vermin proof. It has negligible smoke contribution even at high temperatures. The new tile is available in six colors, in 80 gauge thickness in nine-inch squares. **B. F. Goodrich Flooring Co., Watertown, Mass.**

For more details circle #936 on mailing card.

Magi-Carpet System Facilitates On-Location Shampoo

Magi-Carpet with K-248 shampoo machine and a small vacuum cleaner make up

the Magi-Carpet System. The new shampoo material, Magi-Carpet, was developed by the Technical Department of Mohawk Carpet Mills after three years of research. With the carpet shampoo machine K-248 developed by The Kent Company especially for use with Magi-Carpet, and a small, compact but powerful vacuum cleaner, carpets can be easily and completely cleaned on location.

Action of the shampoo detergent eliminates the danger of yellowing the carpet, yet it is completely safe, even on cotton carpeting. It dries quickly and a soil retardant built into the shampoo helps reduce the re-soiling rate. The Kent rug shampoo machine is designed to reduce carpet wear in cleaning and both machine units are readily portable and easy to use. **The Kent Company, Rome, N.Y.**

For more details circle #937 on mailing card.

(Continued on page 240)

Carolina your dependable source

for All Hospital Textiles . . .

- BATHMATS
- BASSINET LINERS
  - *pads*
  - *padding*
- BEDSPREADS
- BLANKETS
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  - *Crib*
  - *Ether*
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- PILLOW CASES
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- SHEETING
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  - *unbleached*
  - *jade green*
- TAPE
- TABLE LINENS
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  - *napkins*
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- TICKING
- TOWELS
  - *terry*
  - *huck*
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  - *kitchen*
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HIA HOSPITAL INDUSTRIES ASSOCIATION

Whatever your needs—from a wash cloth to a bolt of drapery material—Carolina has it or can get it. **Your textile problems are our business.**

More important, Carolina has in stock a complete selection of grades—from service weights to luxury items, unbleached muslin to percale—to meet your individual requirements, *and your budget!*

A Carolina representative will be glad to show you samples, help you in any possible way.

Send for a complete Carolina catalog if you do not have one readily available—14-page section on textiles included.

IMPORTANT: Carolina carries only *branded* merchandise—your guarantee of dependable uniformity. High tensile strength, long wearing characteristics are inherent in products bearing the maker's own name.

CAROLAB hospital supplies

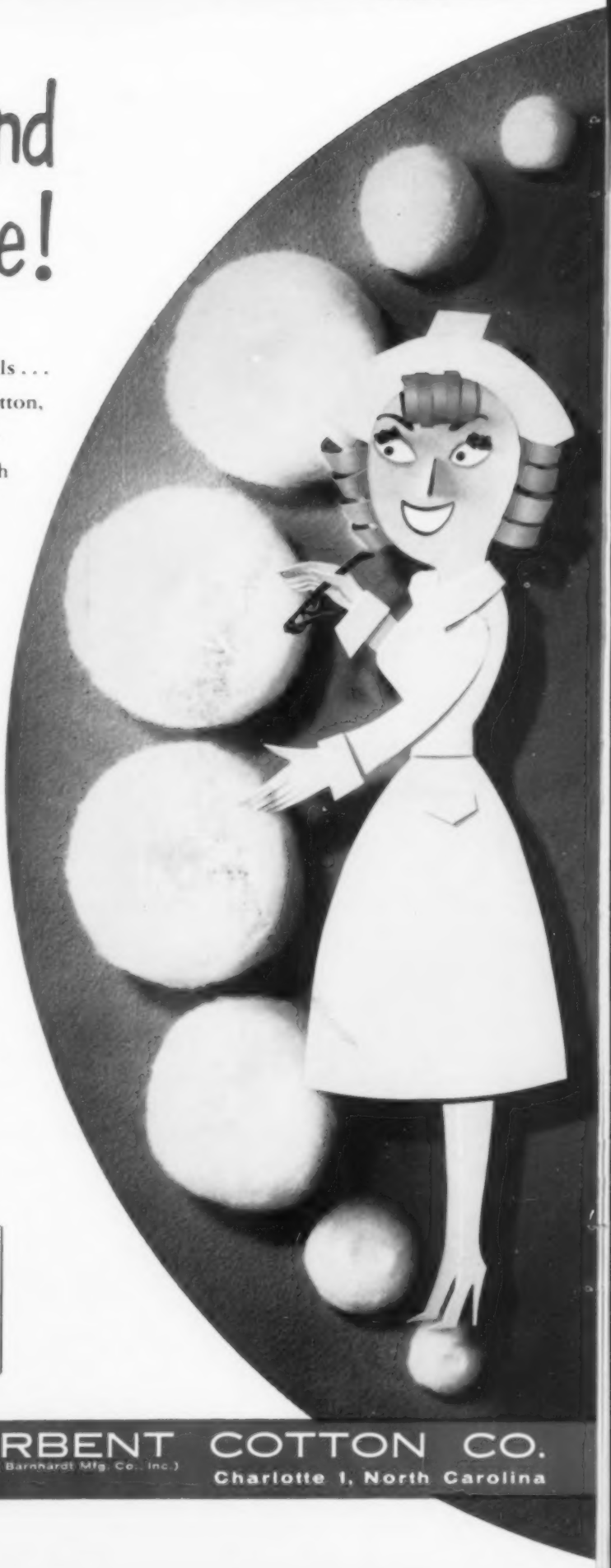
Carolina Absorbent Cotton Co.

(Division of Bernhardt Mfg. Co.)

CHARLOTTE 1, NORTH CAROLINA

quality products of cotton since 1900

You Can See and Feel the Difference!



See the smooth finish of these Carolab cotton balls . . . feel the firmness, too. This is virgin long-staple cotton, carefully spun so that there are no nibs, no loose wispy ends. Carolab cotton balls are soft, yet with proper density for greater absorbency.

There is a complete range of sizes—five to meet every need in the hospital . . . from nursery to accident ward, from pharmacy to blood bank and laboratories.

Carolab cotton balls are economical, too. They replace sponges in many hospital procedures to provide improved technic as well as lower cost. You will find Carolab is truly a better ball at a lower price.

Manufactured Where Grown

super	2000 per case	
special	2000	special is same size as large
large	2000, 4000	but is almost twice as dense
medium	4000, 8000	
small	8000	

rayon balls also available in the four larger sizes; same packing and price.

On request, a large sample case of the complete line of Carolab surgical dressings will be delivered for inspection by OR, OB and CRS supervisors, purchasing agent or business manager, and other interested hospital personnel.

CAROLINA ABSORBENT COTTON CO.
(Division of Barnhardt Mfg. Co., Inc.)
P.O. 2176 Charlotte 1, North Carolina

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THE MODERN HOSPITAL, published monthly at Chicago, Illinois, for October 1, 1958.

1. The names and addresses of the publisher, editor, and business managers are:

Publisher: The Modern Hospital Publishing Co., 919 N. Michigan Ave., Chicago 11, Illinois.

Editor: Robert M. Cunningham Jr., 919 N. Michigan Ave., Chicago 11, Illinois.

Business Manager: Stanley R. Clague, 919 N. Michigan Ave., Chicago 11, Illinois.

2. The owner is: (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual member, must be given.)

The Modern Hospital Publishing Co., Inc., 919 North Michigan Avenue, Chicago 11, Illinois.

All of the stock is owned and held by F. W. Dodge Corporation, 119 West 40th Street, New York 18, N. Y. All of the common stock of F. W. Dodge Corporation is held by the following Voting Trustees namely: James McV. Breed, 15 Broad Street, New York 5, N. Y.; Paul Abbott, 40 Wall Street, New York 5, N. Y.; Howard Barringer and T. Oliver Morgan, both of 119 West 40th Street, New York 18, N. Y.; and George W. Morgan, 76 Beaver Street, New York 5, N. Y., under Voting Trust Agreement dated as of June 12, 1928 as amended and extended to May 2, 1966 by Extension Agreement dated as of February 19, 1957.

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5. The average number of copies of each issue of this publication sold or distributed, through the mails or otherwise, to paid subscribers during the 12 months preceding the date shown above was: (This information is required from daily, weekly, semiweekly, and triweekly newspapers only.)

ROBERT M. CUNNINGHAM, JR., Editor

Sworn to and subscribed before me this 26th day of September, 1958.
[SEAL]

J. P. McDERMOTT, Notary Public.
(My commission expires Sept. 27, 1961)

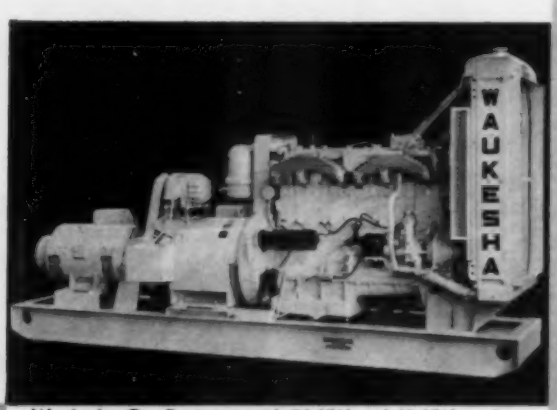
For additional information, use postcard facing Cover 3.

IN AN EMERGENCY

AUTOMATIC, IMMEDIATE *electric* SERVICE

For—essential lighting . . . surgery suite . . . laboratories . . .

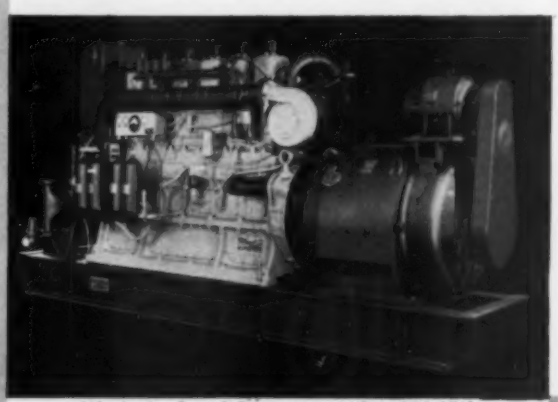
X-ray . . . dietary . . . boiler rooms . . . emergency elevators . . . and ancillary equipment



Waukesha Gas Enginator with 50 KW and 60 KW tandem generators for St. Catherine's Hospital—Kenosha, Wisconsin

●

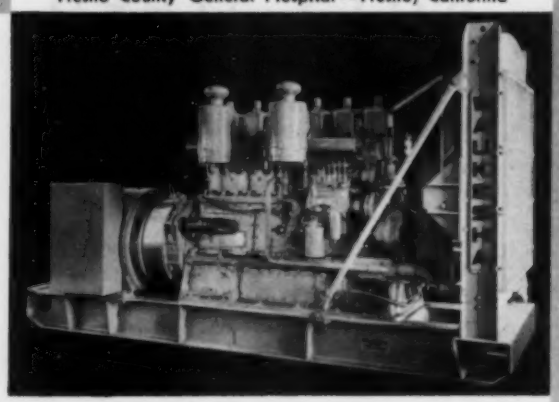
Waukesha Diesel Enginator rated at 250 KW for the Fresno County General Hospital—Fresno, California

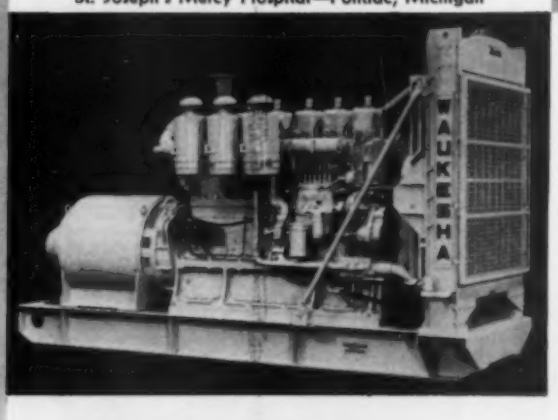


Waukesha Diesel Enginator rated at 300 KW for the Lutheran Hospital—Cleveland, Ohio

●

Waukesha Diesel Enginator rated at 300 KW for St. Joseph's Mercy Hospital—Pontiac, Michigan





WAUKESHA ENGINATORS®

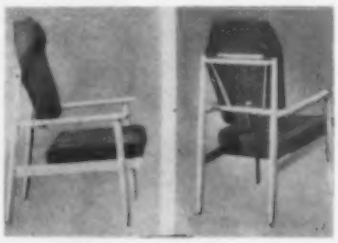
Developed by over 50 years' experience in building heavy-duty internal combustion engines and electrical equipment, Waukesha Enginators have a world-wide proven record of reliability. Made in Diesel and carburetor fuel models, up to 800 KW capacity. Send today for descriptive literature.

384

WAUKESHA MOTOR COMPANY, WAUKESHA, WISCONSIN • NEW YORK • TULSA • LOS ANGELES

High-Back Adjustable Chair for the Convalescing Patient

Designed especially for use by the convalescing patient, the new High-Back adjustable chair has a higher-than-usual seating surface. This feature, together with the low degree of pitch, makes it easy for the convalescing patient to get in and out



of the chair with minimum effort. The back section can be adjusted up or down by the patient while seated in the chair. Under normal conditions the patient can handle the simple adjusting process himself. Intermediate adjustments are easily made by the friction lock. The frame is sturdily constructed of Select Northern Hard Birch and the foam rubber seat and backrest are upholstered in a choice of colors. The chair is designed to conform with both the Carrom Series 2800 and the 2900 lines and is available with ferrules or with metal glides. **Carrom Industries, Inc., Ludington, Mich.**

For more details circle #938 on mailing card.

Nibroc Paper Towels Have Improved Absorption

A new method of embossing is used on the Improved Nibroc Paper Towels to give them greater absorbency and softness. They are free from lint and strong even when wet. A special bleaching process for the white towels makes them "hospital white," and the improved towels are also available in natural. All towels in the line have improved absorbency, softness and strength and they are now offered with the C-fold as well as single and double multifolds. **Brown Company, 150 Causeway St., Boston 14, Mass.**

For more details circle #939 on mailing card.

Deep Fat Fryer Provides Automatic Operation

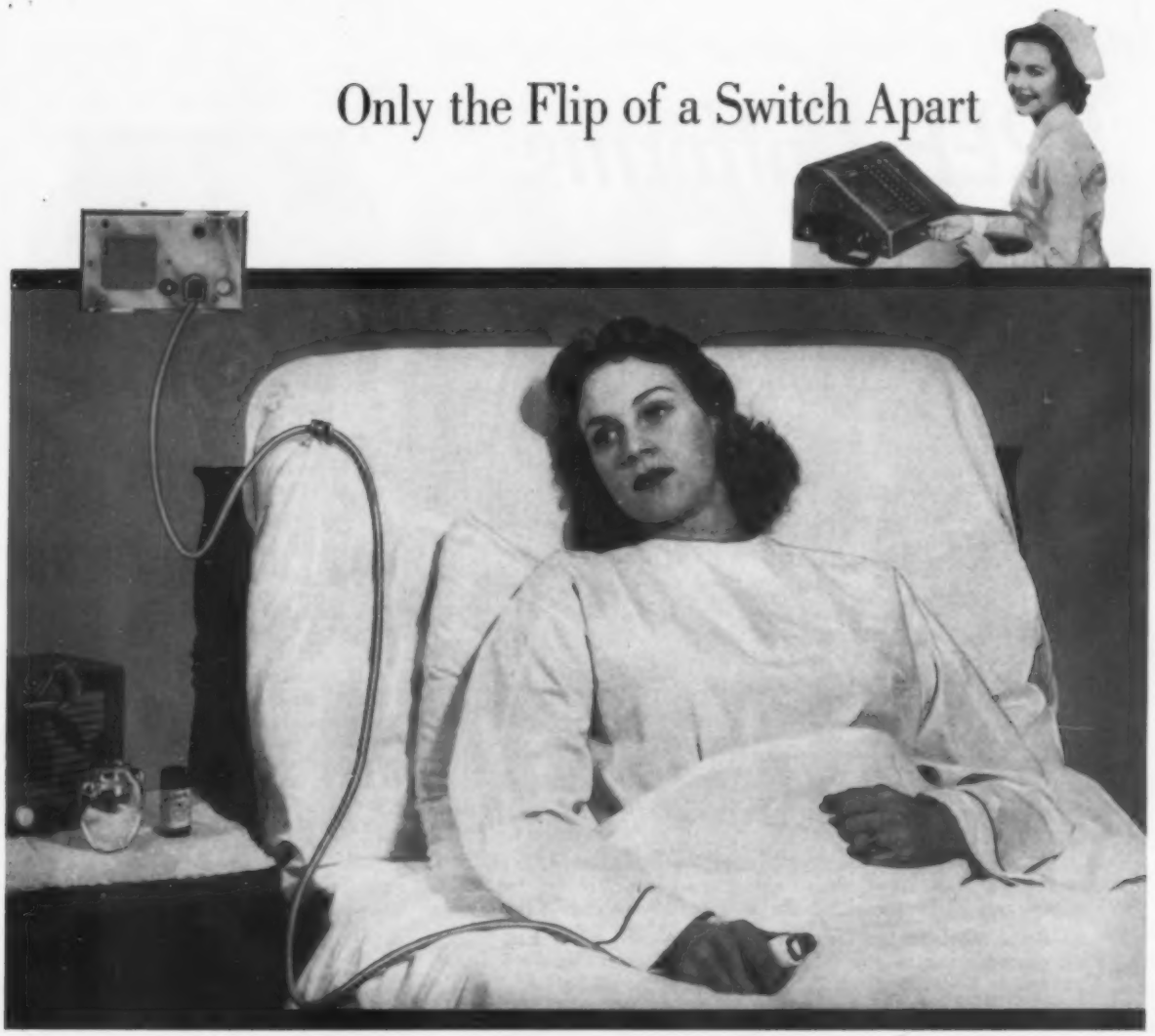
Model 27 of the Unifryer is a new automatic deep fat fryer providing fifty per cent additional heating capacity to maintain optimum fat temperatures during continuous cooking periods. Three immersion heaters are used in the new model for the added heat so that even a maximum rate of food insertion will not lower fat temperature more than a few degrees.

The Unifryer has a 48-inch long fat container. A screw conveyor turns slowly in the hot fat, pushing the food along to one end where a revolving separator screen automatically stops cooking by lifting the food out of the fat and depositing it in a receiving pan. Unifryers have automatic controlled cooking and marks indicate where to insert different foods for varied cooking times. The increased heat ensures searing action to seal in natural juices and flavors. **Gifford-Wood Co., Hudson, N.Y.**

For more details circle #940 on mailing card.

(Continued on page 244)

Only the Flip of a Switch Apart



"Vokalcall"*... audio-visual nurses' call systems providing two-way voice communication between patient and nurse... is fast becoming indispensable in modern hospital administration. Why? Because "Vokalcall" benefits the entire hospital. Patients recover faster when they feel secure... when they know that by the mere flip of a switch they can hear their nurse's voice and talk to her. Nurses benefit from a feeling of raised morale and accomplishment. They concentrate on direct bedside care, save footsteps, attend more patients. These good effects extend to other departments of the hospital. Greater overall accomplishment, reduced operating costs, and increased good will result.

"Vokalcall" systems are the products of constant research and development by the Auth Electric Company in signaling and communication systems for hospitals. For a copy of the most recent booklet "Vokalcall Audio-Visual Nurse's Call Systems" write to the address below.

Auth
SINCE 1892

Manufacturers of
ELECTRICAL SIGNALING, TIME AND COMMUNICATION SYSTEMS FOR HOSPITALS, SCHOOLS, HOUSING, INDUSTRY AND SHIPS

* Registered

Auth Electric Company, Inc.

Dept. A6 LONG ISLAND CITY 1, NEW YORK

Special Molds for Custom Surgical Gloves

A custom surgical glove service, utilizing specially-made ceramic molds cast to the surgeon's specifications, is now provided by Pioneer Rubber Company. Unusual fitting problems can be solved through the special service. The special molds are made from outline drawings of the surgeon's hands, then labeled with his name and kept on file for his use. As part of its complete hand protective service for the medical profession, Pioneer also offers surgical gloves in neoprene for those with allergies to latex, and gloves for doctors and nurses with unusually small hands. **Pioneer Rubber Co., Willard, Ohio.**

For more details circle #941 on mailing card.

Self-Adhering Gauze Tape for Bandaging

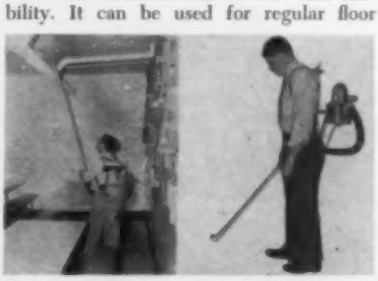
Stixon is the name given to the new self-adhering gauze tape added to the Medical Fabrics line of bandages. Stixon will not stick to skin or hair, only to itself, and leaves no gummy deposits. It combines gauze and adhesive tape in one unit. It can be sterilized and is supplied in ten yard rolls, cut ½, ¾, one and two inches, in flesh color. **Medical Fabrics Co., Inc., 10 Mill St., Paterson 1, N.J.**

For more details circle #942 on mailing card.

Pac-Vac Cleaner Straps to Operator's Back

The tubular frame of the Pac-Vac cleaner fits comfortably on the operator's back for use and can be adjusted with the wide straps. The motor unit is interchangeable with the Tornado tank cleaner. It mounts on a "Skrap-Trap" which keeps heavy objects from reaching the air impeller.

Pac-Vac features convenience and mobility. It can be used for regular floor cleaning, using up to a 22-inch tool, and for all types of overhead work with extension handles. It is especially useful for cleaning stairs, shelves, storage bins and in congested areas. **Breuer Electric Mfg. Co., 5100 N. Ravenswood Ave., Chicago 40.**



For more details circle #943 on mailing card.

(Continued on page 246)

shock?

OPERATION IS POSSIBLE WITH

life-saving

Levophed®

bitartrate

natural
antishock
pressor
hormone

Levophed raises blood pressure in seconds, makes the "inoperable" patient in shock operable.

Life-saving Levophed is effective even when transfusions fail. Its dependable vasopressor action converts the "poor risk" patient to a good risk.

"...the most satisfactory form of treatment to date"[1]

1. Briller, S. A.: M. Clin. North America 41:619, May, 1957.

Winthrop LABORATORIES, New York 18, N. Y.

Levophed (brand of levarterenol), trademark reg. U. S. Pat. Off.

For additional information, use postcard facing Cover 3.

Redesigned Air Conditioning in Model C-77 Isolette

The outstanding advantages of earlier models are retained in the new Model C-77 Isolette, together with several important new features. The air conditioning chamber has been completely redesigned with rounded inside corners and edges for easy cleaning. There are no inaccessible surfaces to become contaminated. Flow of

air through the chamber gives precise control of humidity and temperature. The Air-Shields Micro-Filter ensures practically complete removal of contaminants and the new model can be connected to outside air or use nursery Micro-Filtered air.

Another new feature is the compact, lightweight power unit containing the air-circulating blower, heating unit and the operating and safety thermostats. Provision is made in the Isolette for safe oxygen administration with concentrations limited to a maximum of 40 per cent. **Air-Shields, Inc., Hatboro, Pa.**

For more details circle #944 on mailing card.

Positive Air Purification Now Possible With Kathabar

Extensive research on the important problem of air purification in the hospital has recently brought out new information on the Kathabar System which should be of interest to the hospital administrative staff and architects. Over four years of tests by the Research Foundation of the University of Toledo indicate that the Kathabar System can guarantee the quality of air entering an operating room. Results of the survey are summarized in a brochure, "Air Hygiene for Hospitals," which is available from the manufacturer.

Employing a combination of mechanical impingement and chemical germicidal action, the Kathabar System was found to provide effective, consistent and reliable control of microorganisms in the air. It also proved effective in maintaining the proper humidity to prevent explosions from anesthetic gases. In addition to its bactericidal efficiency, the system provides desired cooling when supplied with refrigeration energy and will humidify or dehumidify as required. **Surface Combustion Corp., Toledo 1, Ohio.**

For more details circle #945 on mailing card.

Functional Color Kit Assists in Planning

Specifying the proper colors to use in the various areas of the hospital to achieve the most desirable effects is greatly facilitated with the new Functional Color Kit now available. Developed by a group of thirteen paint manufacturers in the United States and Canada, the kit contains 36 paint color chips identified by number, showing reflectance percentages of each. The colors are divided into groups under Functional Colors, Decorative Colors and Special Colors.

A brochure prepared by a foremost color authority on "The Scientific Application of Color to Hospitals" is included in the kit. It points out the value of using

colors as a form of psychotherapy in the case of the convalescing patient, and as an aid to seeing and sharpening visual acuity for staff and personnel. Full color illustrations demonstrate the recommended colors for various areas of the hospital and the reasons for the selection of each are explained. The kit is offered as an aid to administrative personnel in acquiring a hospital with an environment conducive to the promotion of good patient morale and improved convalescence, and to maximum efficiency of all personnel. **Colorizer Associates, 345 N. Western Ave., Chicago 12.**

For more details circle #946 on mailing card.

(Continued on page 248)

SLOW LEAK IN YOUR BUDGET?

Halt it with new "Rippletex" C-fold towels

Money dribbling away because your paper towels aren't earning their keep? With the new "Rippletex" C-fold towel now available in the famous Nibroc® line, you can switch to Nibroc and save money. Nibroc's perfect balance of absorbency, strength, softness, reduces waste—cuts cost-per-user—brings sharp savings in annual towel costs. Nibroc "Rippletex" C-fold towels in brilliant "White Magic" white are embossed for increased softness, greater bulk—better absorbency. They fit *any* C-fold cabinet. Mail the coupon today for samples and name of nearest distributor.

Brown Company
150 Causeway St., Boston 14, Mass.

Please send me samples and complete information on Nibroc "Rippletex" C-fold towels.

NAME_____

COMPANY_____

CITY_____ STATE_____

BROWN COMPANY

General Sales Offices: 150 Causeway St., Boston 14, Mass.
Mills: Berlin and Gorham, New Hampshire

NIBROC TOWELS • NIBROC TISSUE • NIBROC CABINETS • NIBROC WIPERS

Numbered Dome Lights for Nurse Call System

New numbered dome lights with numbers which can be clearly seen at a distance are available as part of the Royal Patient-Nurse Communication System or for replacement of room-marking devices in any hospital. Up to three numbers can be used on either side of the dome using two-inch letters or numbers as shown in the illustration. If one-inch numbers are used, as many as four can be mounted on each side. **Royal Communication Systems, 2130 W. 110th St., Cleveland 2, Ohio.**

For more details circle #947 on mailing card.

Heavy Duty Vinyl Sponge Resists Wear and Tear

Packed moist and ready to use in polyethylene bags, the new Simoniz C-100 Heavy Duty Vinyl Sponge resists tearing and wear. It is designed for cleaning walls, windows, floors and for other heavy duty maintenance jobs because of the exceptional absorption and holding of cleaning solutions. Regular soap and detergent mixes can be used with the new sponge which wipes surfaces virtually dry. **Simoniz Co., 2100 Indiana Ave., Chicago 16.**

For more details circle #948 on mailing card.

"Step-Ahead" Floor Finish Resists Marring

"Step-Ahead" is a new self-polishing floor finish containing a chemical developed by the Johnson research department. Know as Polymer-"M", the chemical has small, uniform particles which form a tight, durable protective coating resistant to scuffing, marring, dirt pick-up and rubber marking. An advanced emulsifier system assures self-leveling in the application of the finish as well as easy removal for stripping. "Step-Ahead" reduces maintenance time due to its long-lasting protection. **S. C. Johnson & Son, Inc., Racine, Wis.**

For more details circle #949 on mailing card.

Wood-Grain Plateboard Is Low-Cost Surfacing Material

Low cost and luxurious appearance are features of the new paneling ma-

terial known as Wood-Grain Plateboard. The improved hardboard, available in both smooth-one-side and smooth-two-sides types, is available in oak or walnut grain, patterned in Random, Verti and Blok scoring. Also available with a smooth surface with exceptional paintability, the improved Plateboard is manufactured by a process which achieves a close tolerance and precise adherence to specifications. Plateboard is manufactured in a new plant at Alpena, Michigan, which also produces a rigid insulating board with new properties. **Abitibi Corp., Penobscot Bldg., Detroit 26, Mich.**

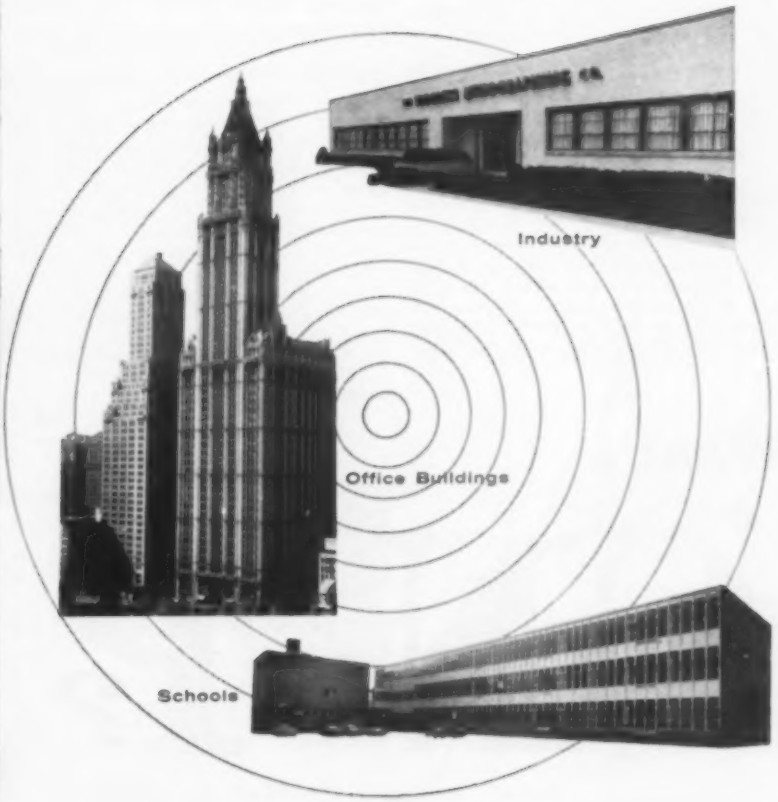
For more details circle #950 on mailing card.

Oxygen Therapy Regulator Is Small and Economical

Small size and low cost are features of the new O.E.M. Oxygen Therapy Regulator. The high pressure reducing regulator weighs less than 22 ounces, yet it has been approved safe by Underwriters Laboratories, according to the manufacturer, for use with high pressure gas cylinders. The new piston-operation eliminates the diaphragm and employs "O" Rings, precise gaskets that contain the 2200 pounds of high pressure without a leak. The regulator has a tough, enduring DuPont teflon seat. It has a minimum number of parts and of service problems and is available for every oxygen therapy use. **O.E.M. Corporation, East Norwalk, Conn.**

For more details circle #951 on mailing card.

(Continued on page 250)



Our business is communications

. . . a gentle chime . . . a blasting horn . . .
or a complete audio-visual communication system

Sperti Faraday leads in the instant sound or sight communication systems that speed today's business or institutional contacts. Whatever your problem, whether simple or complicated our engineers are at your service to assist you in designing the system that suits your needs.

This service is available to users without obligation. Simply call your nearest Sperti Faraday representative or write to Sperti Faraday, Inc., Adrian, Michigan. *In Canada*, write Sperti Faraday, Ltd., Montreal.

SINCE 1875 DESIGNERS AND PRODUCERS OF VISUAL AND AUDIBLE SIGNALS

Adrian, Michigan

Sperti Faraday Inc.

Specialists in: FIRE ALARM SYSTEMS • ELECTRICAL CLOCK SYSTEMS • HOSPITAL PATIENT OBSERVATION • CLOSED CIRCUIT TV • AUDIBLE SIGNALS • ANNUNCIATORS • CODED PAGING SYSTEM • SYNCHRONOUS CLOCKS • TRANSFORMERS • CONTACT DEVICES

Germ-Proof Process Incorporated into Floor Covering

Permachem is a permanent germ-proofing process which is incorporated into Amtico floor coverings. The resulting products kill or inhibit germs and fungi, facilitating the problem of removal of possible infection. The process is introduced in Amtico Care-Free Vinyl and in Amtico Conductive Vinyl, the static tile especially designed for use in operating rooms, x-ray rooms and laboratories. In tests, Permachem germ-proofing proved effective against a wide variety of bacteria and spores, yet it is odorless, colorless, durable and non-toxic. Treated Amtico floors are said to be mildew-proof, fungi-proof and mold-proof as well. Each tile is impregnated with Permachem's antiseptic formula. Tests indicate that repeated washing does not destroy the protective efficiency. **American Biltrite Rubber Co., Perrine Ave., Trenton 2, N. J.**

For more details circle #952 on mailing card.

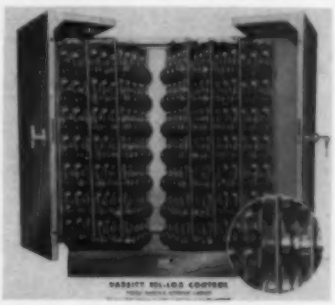
Brite Shine Floor Wax Reduces Maintenance

Brite Shine self-leveling Floor Wax needs to be applied at long intervals only. Made from pure Carnauba wax, Brite Shine is emulsified under a specially controlled process without the addition of substitutes or synthetics. The resulting liquid wax is long wearing with high gloss. It is anti-skid, water-resistant and smooth, giving a strong protective finish to floors of all types. **E. J. Scarry & Co., 1620 Market St., Denver 2, Colo.**

For more details circle #953 on mailing card.

Padlock Storage Cabinet Protects Locks and Speeds Handling

The Tel-Lox padlock storage cabinet not only provides safe storage for padlocks, but permits filing for security and ease of distribution. The handy hook numerical indexing system gives accurate records regarding location and distribution. The sturdily constructed cabinet, with



maximum capacity of 392 locks, has free-swinging hook panels and vitascope doors for complete visibility and accessibility.

The Tel-Lox cabinet can be attached to the wall or fastened to a movable table to simplify and speed handling of the padlocks. A high-quality locking device and handle protect contents when not in use. **P. O. Moore, Inc., Glen Riddle, Pa.**

For more details circle #954 on mailing card.

High-Humidity Oxygen Tent Has Simple Controls

The humidity range of the new Model Twenty-Five high-humidity oxygen tent introduced by Ohio Chemical is regulated by simple controls. The tent is designed to provide an atmosphere rich in oxygen at 100 per cent humidity, with minimum external wetting and at controlled temperatures. Filling and draining of the large-capacity reservoir are facilitated by the clear, pliable, plastic tube at the lower front section of the tent which also provides visible indication of the water level. **Ohio Chemical & Surgical Equipment Co., Madison 10, Wis.**

For more details circle #955 on mailing card.

Bi-Tran Permits Educational Use of Commercial TV Facilities

Bi-Tran, a multiplexing TV system, would allow two different programs to be broadcast simultaneously on any TV channel. Shortage of channel space has restricted the spread of mass educational television. With Bi-Tran the resources and equipment of an existing commercial transmitting station can be utilized for educational programs simultaneously with the transmission of regularly scheduled shows. Both programs are transmitted on the same channel, and by means of a simple attachment at the receiver end, either of the two programs can be received at will.

This second programming outlet provides the opportunity for information of pertinence to hospitals, students, doctors and others to be transmitted while regular programs are shown on the same channel. **Blonder-Tongue Laboratories, Inc., 9 Alling St., Newark 3, N.J.**

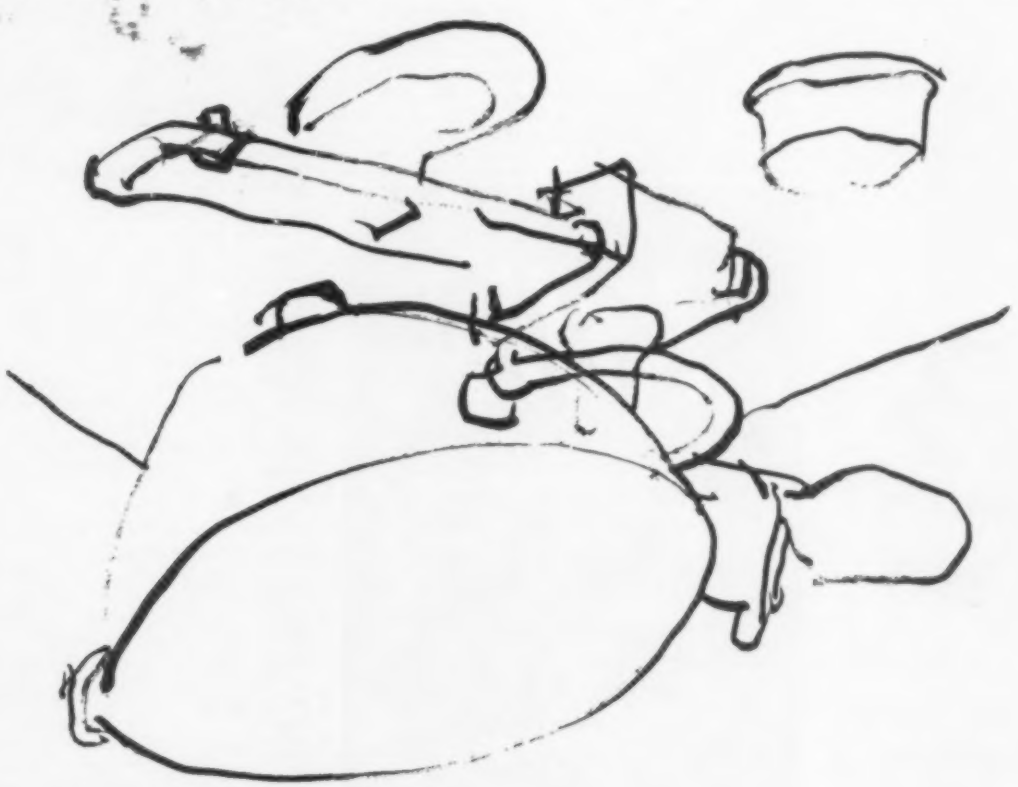
For more details circle #956 on mailing card.

(Continued on page 252)

"IRREVERSIBLE" SHOCK REVERSED

In all types of stress conditions, when corticoid requirements are multiplied as much as ten times or more, Solu-Cortef (i.v. hydrocortisone) "triggers" vasopressors[1] to maintain circulatory efficiency.[2,3] It has reversed "irreversible" surgical or hemorrhagic shock.[4]

References: 1. Fritz, I., and Levine, R.: Am. J. Physiol. 165:456 (May) 1951. 2. Hall, W. H., and Gold, D.: A.M.A. Arch. Int. Med. 96:418 (Sept.) 1955. 3. Kinsell, L. W.: Anesth. & Analg. 35:294 (July-Aug.) 1956. 4. Hull, E.: Kansas City M. J. 33:19 (March) 1957.



Solu-Cortef®

in the time-saving

MIX-O-VIAL®

the first hydrocortisone for direct intravenous injection

Dosage – Inject intravenously in 30 to 60 seconds. Repeat injections of half a Mix-O-Vial may be given after 1, 3, 6, and 10 hours.

Supplied – As a 100 mg. and a 250 mg. Mix-O-Vial.

®TRADEMARK, REG. U.S. PAT. OFF.

Upjohn The Upjohn Company Kalamazoo, Michigan

Silver Handling Equipment Features Dip Tank and Cylinder

Two new developments in Steril-O-Matic silver handling equipment are now available. The Model ST-1 Dip Tank has a new temperature control unit for spotless drying and sterilization of silver flatware. The contact-type thermostat is easily accessible and adjustable to fit any special requirements. The tank is made of heavy gauge stainless steel with carrying handles, heating element and operating cord.

The new Steril-lite Flatware Cylinder is extremely light and easy to handle, yet it is rigid, heat resistant and strong. It is made of ethylene polymer, is odorless and resists mineral and vegetable oils, salt brines and alkalies. It has an attractive appearance, withstands shocks, holds its shape in use and is practically indestructible. **Steril-O-Matic Co., Inc., 4530 N. Keystone Ave., Indianapolis 5, Ind.**

For more details circle #957 on mailing card.

Pre-Treated Sweeping Mops for Dustless Cleaning

Majestic Sweeping Mops pre-treated with Velva-Sheen for dustless sweeping are now available. The new treated mops are packaged in polyethylene bags, ready for use. The new sweeping mop does not require laundering and is easily re-treated with Velva-Sheen when necessary. Velva-Sheen for use in re-treatment is supplied in sizes ranging from 12-ounce bottles to 55-gallon drums. **Majestic Wax Co., 1600 Wynkoop, Denver 2, Colo.**

For more details circle #958 on mailing card.

"Screen-Bak" Discs Now Clean Tile Floors

The problem of stripping off old floor wax on tile floors in institutions where

heavy coatings are required for heavily traveled areas is now solved with the use of "Screen-Bak" discs. The new removal procedure involves the use of the disc made of silicon carbide abrasive coated on a cloth backing. The open mesh cloth backing is new in the use of abrasives and permits the disc to be rinsed clean in warm water when wax and dirt begin to accumulate. Maximum life is thus obtained from the abrasive grains and floors can be completely stripped and cleaned, ready for re-waxing. The discs are used with floor polishing machines for fast and thorough floor maintenance. The method can be used on rubber tile, terrazzo and vinyl tile. **Behr-Manning Co., Div. of Norton Co., Troy, N. Y.**

For more details circle #959 on mailing card.

White-Wunder-Wipe Cloth for Dusting and Heavy Duty Wiping

General cleaning and dusting as well as heavy duty wiping chores in laboratories, boiler rooms, duplicating rooms and similar areas are facilitated with the new White-Wunder-Wipe Cloth. The wipers are made of 100 per cent cotton fibers and will absorb nine to ten times their weight in water and seven to eight times their weight in oil. They are packed 50 wipers to the pound. **Textile Products, 181 Chestnut St., P. O. Box 638, Newark 1, N. J.**

For more details circle #960 on mailing card.

Color Chip Rubberlike Is Thermoplastic Floor Covering

A floor-protecting runner for heavy traffic areas in hospitals and other public buildings is offered in Color Chip Rubberlike. The new thermoplastic floor covering product is flecked with two colors by means of plastic chips added during manufacture. Colors available are red and white or green and white flecks against black. **Bird & Son, Inc., East Walpole, Mass.**

For more details circle #961 on mailing card.

Emdee Margarine Has Unsaturated Fatty Acids

A new table spread and cooking fat which will not elevate the level of blood cholesterol is offered in Emdee Margarine. Its main source of fat is nonhydrogenated corn oil, which is high in unsaturated fatty acids, particularly linoleic. It has palatability and texture comparable to better margarines and is fortified with vitamins A and D. **Pitman-Moore Co., 1200 Madison Ave., Indianapolis 2, Ind.**

For more details circle #962 on mailing card.

(Continued on page 254)

Dialamatic Tube System Controls Despatch of Carriers

Fast, silent and speedy delivery of messages, instructions, prescriptions and even small objects is achieved without error or delay with the Grover Transitube pneumatic tube system. Hospital paper work is speeded since all written information, orders, charts, records and the like can be transmitted immediately.

The Grover Dialamatic system utilizes telephone dial equipment to direct carriers

from any station in the system to any other automatically. The carrier is placed in the dispatch magazine and the destination dialed. The control panel for the system releases the carrier in its proper turn, directing it to its destination and recording its location at every instant until it is removed at the receiving end. The controlled dispatch eliminates the possibility of overloading, reduces blockades in the system and permits more efficient and effective use of the tube system at considerably less cost. Carriers have no built-in signal system which reduces maintenance and permits use of carriers of any manufacture. Existing tube systems can be converted to Dialamatic. **Grover Co., 25525 W. Eight Mile Rd., Detroit 40, Mich.**

For more details circle #963 on mailing card.

Intravenous Standard Is Tip Resistant

Engineered with a low center of gravity, the Security Intravenous Standard can be tilted without falling over. It is readily adjustable in height from six to nine feet with a positive action sleeve-type locking device without protruding knobs or handles. Weight is distributed for ease of rolling without tipping and the two-inch ball bearing swivel casters are conductive, rugged and silent. Hard finish aluminum forms the upright portion of the standard, providing light weight with long wear. **Precision Dynamics Corp., 2701 Burbank Blvd., Burbank, Calif.**

For more details circle #964 on mailing card.

Floor Polisher Is Economically Priced

Designed for small and medium sized floor area maintenance, the new Model PRO-13 floor polished is a medium weight machine available at an economical price. It has a powerful motor and interchangeable brush attachments for scrubbing, polishing, buffing and steel wooling all types of floors. **Hild Floor Machine Co., Inc., 1217 W. Washington Blvd., Chicago 7.**

For more details circle #965 on mailing card.

(Continued on page 256)

Now from Carrier:

A NEW LOW-COST WAY TO AIR CONDITION YOUR PATIENT ROOMS!

Now existing hospitals can obtain the benefits of year-round central air conditioning *without* major alterations, interruptions and high first costs. Carrier, leader in air conditioning, has developed the means in its new Model 37E All-Air Weathermaster® Units.

These attractive units replace radiators. They combine an all-air high velocity system with existing steam heating services to eliminate installation costs of water lines, drains and new electric service to each room. They also eliminate the cost of cutting multiple small openings in exterior building walls.

The new Model 37E Units provide year-round, dial-controlled climate in each room. They assure constant draftless air circulation and positive ventilation without cross circulation between rooms. They are quiet and easy to maintain, with no moving parts in the room.

Is this new way best for every hospital?

It is—if existing steam services are in good condition, since these services will be incorporated in the complete air conditioning plant. However, if steam services are ready for replacement, the Carrier Modular Weathermaster System is undoubtedly best.

No matter what problems a hospital poses, there's a Carrier System to meet all requirements economically and without even temporary loss of space. A Carrier expert will be glad to advise which way is best. For information on hospital air conditioning, call your nearest Carrier office. Or write Carrier Corporation, Syracuse, New York.

BEFORE: This unsightly, old-fashioned radiator detracted from the appearance of the patient's room. Besides being a dust trap, its only function was to furnish heat in cold weather.

AFTER: The Carrier 37E All-Air Weathermaster Unit, attractively enclosed in a standard cabinet, provides year-round heating and air conditioning. Same unit may be furred in.

Air Conditioning
Refrigeration
Industrial Heating

®Reg. U.S. Pat. Off.

For additional information, use postcard facing Cover 3.

Three Years of Research Goes Into Electrocardiograph

The new Model 300 Electrocardiograph developed by Birtcher is the result of more than three years of engineering and field

research. Several unique features are incorporated into the new unit which employs transistors and printed circuits where possible. It has a two-speed paper drive which provides a 100 per cent magnification of the horizontal. A switch automatically blanks the machine as it is turned from lead to lead. Control grouping permits one hand to cover all operating controls on the unit. The tracing is standard 50mm width produced on standard 2½-inch heat-sensitive paper. The new Model 300 is finished in beige and off-white chip-proof baked enamel and weighs approximately 29 pounds fully packed. **The Birtcher Corp., 4371 Valley Blvd., Los Angeles 32, Calif.**

For more details circle ₤966 on mailing card.

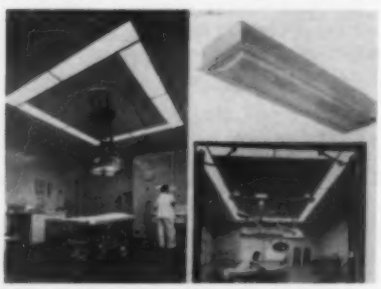
Panelyte Laminate Introduces Ten Added Colors

Ten attractive new colors are now available in St. Regis Panelyte laminate material for walls, counter tops, backsplash, and other areas requiring an attractive, durable finish. The marproof material brings three new colors, Cerulean Blue, Mist Green and Flame, to the Galaxy line which has delicate metallic surfaces showered with flecks of gold and silver. Seven new colors and wood grains in the regular Panelyte line include Autumn Walnut and Champagne Walnut, Brown Birch, Michigan Cherry, Mist Green Solid, Tan Breccia Marble and Light Gray Oystershell. Colors and designs are available to fit every decorative need. **Panelyte Div., St. Regis Paper Co., 150 E. 42nd St., New York 17.**

For more details circle ₤967 on mailing card.

Fluorescent Lighting System Designed for Operating Rooms

High light levels without discomfort are provided in the operating room by the new Alkco No. 223-1 fluorescent lighting system, due to the use of an asymmetric beam. A prismatic controlled diffuser is used in combination with certain internal fixture design advancements. Units are installed in a continuous rectangle around the operating light center, achieving a carefully



calculated asymmetric beam which permits concentrations of higher levels on and around the operating table. The high light levels blend the concentrated beam of the operating light into the background, minimizing eye accommodation when looking in and out of the localized light. They provide adequate working light for other members of the surgical team, and uniform, comfortable, shadowless general lighting throughout the entire room. **Alkco Mfg. Co., 4242 Lincoln Ave., Chicago 18.**

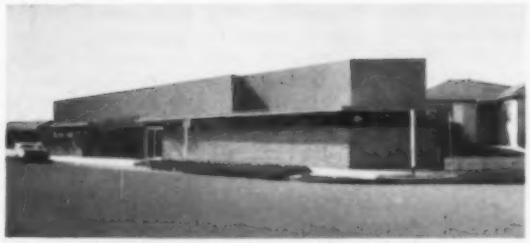
For more details circle ₤968 on mailing card.

Coordinated Wall Coverings in Five Basic Qualities

Five basic qualities, ranging from a heavy duty vinyl quality for maximum protection areas known as Royal Guard, to a lightweight washable wall covering called Princess Guard, make up the new Guard Coordinated System of Architectural Wall Coverings. Developed specifically for institutional and commercial installations, the new Guard System is color coordinated in the five distinct qualities, permitting their interchangeable use in various wall areas without sacrifice of color scheme. Over fifty base colors are used in the new system to allow a full selection. The line contains twenty patterns and 205 styles. **Columbus Coated Fabrics Corp., 7th at Grant Aves., Columbus 16, Ohio.**

For more details circle ₤969 on mailing card.

(Continued on page 258)



EXECUTIVE OFFICES of Allied Hospital Management Co. — Los Angeles, California.

THIS NATIONAL 'CLASS 32' ACCOUNTING MACHINE facilitates fast, efficient posting of general ledger and other accounting records.

MODERN, EFFICIENT ACCOUNTING MACHINES, like this National 'Class 42', save time, money and effort for Allied Hospital Management Co.

BENTLEY MORRISS, Vice President of Allied Hospital Management Co.

"Our *National* System saves us $15,000 a year... returns 81% annually on investment."

—Allied Hospital Management Co., *Los Angeles, California*

"During our original investigation of various accounting procedures and methods, we visited and discussed our problems with many people in hospital management," writes B. Morriss, Vice President of Allied Hospital Management Co. "Our final decision to install a National System was the result of thorough research.

"Our five National Accounting Machines have proved to be most satisfactory and have produced excellent results. We are highly pleased with the way they have cut down on our clerical costs; each machine saves us the extra expense of one full-time clerk. In addition we've found our Nationals are extremely simple to operate, making the training of new personnel an easy matter.

"Our figures prove that all of these advantages have provided substantial savings; we now know our National System saves us $15,000 a year . . . a return of 81% on our investment. We highly recommend Nationals for any hospital, or hospital management organization.

Bentley Morriss
Vice President,
Allied Hospital Management Co.

Your business, too, can enjoy the increased efficiency and economy made possible by a National System. Nationals pay for themselves quickly through savings, then continue to return a regular yearly profit. National's worldwide service organization will protect this profit. Ask us about the National Maintenance Plan. (See the yellow pages of your phone book.)

*TRADE MARK REG. U. S. PAT. OFF.

National*

ACCOUNTING MACHINES
ADDING MACHINES • CASH REGISTERS
NCR PAPER (NO CARBON REQUIRED)

THE NATIONAL CASH REGISTER COMPANY, Dayton 9, Ohio
1039 OFFICES IN 121 COUNTRIES • HELPING BUSINESS SAVE MONEY

Turgasept Aerosol Deodorizer Gives Prolonged Odor Neutralization

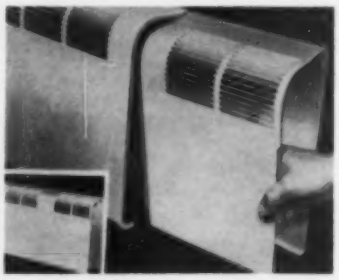
Odors are neutralized immediately upon spraying Turgasept, the new ionic deodorizer aerosol. There is no masking or substituting of odors and in addition, Turgasept is bactericidal and fungicidal to help reduce air-borne pathogens. Turgasept is provided as an aerosol spray for use in operating and patient rooms, nursing homes, laboratories, closets and bathrooms, animal rooms, public rooms and any area with an odor problem. The aerosol spray product removes organic as well as inorganic odors in the air as well as odors which linger about objects.

Turgasept Concentrate is added to hot water for cleaning floors, walls and other areas, destroying odors and providing bactericidal and fungicidal action. The Concentrate can also be placed in air conditioners to deodorize large areas and help reduce air-borne bacteria. Turgasept is supplied in aerosol spray form in 16-ounce size or in concentrate form. **Turgasept Co., Div of Doho, 100 Varick St., New York 13.**

For more details circle #970 on mailing card.

Modernline Wall Radiation Has Standard Components

Styled to meet the needs of modern architecture, the new Modernline series of wall radiation for institutional use features simplicity of installation and standardization of components. In addition to the heating elements, the Modernline unit consists of a backplate assembly, universal pipe hangers and the cover assembly, facilitating installation at minimum cost. The pre-assembled backplate is ready for installation upon unpacking. The pipe hanger is designed for use with any diameter pipe. The cover assembly has rounded contours of the cover section and end caps and is easily installed. The new wall radiation covers are available in five pastel shades in baked enamel finish. **Fedders Quigan Corp., 58-01 Grand Ave., Maspeth, N.Y.**



For more details circle #971 on mailing card.

Time-Saving Maintenance Tools Are Pressure-Activated

Time and materials are saved in painting, floor waxing and spraying with the new Power-Flo tools. The inexpensive tool consists basically of a pressure unit activated by a few strokes of its built-in pump. Ten feet of plastic tubing lead to the specially designed tools which include a pressure-fed paint roller, a pressure-fed floor waxer and a spray unit.

With the Power-Flo Painter, paint is poured into the pressure tank which is activated by a few strokes of the pump. A touch of the valve in the handle brings the paint to the internally-fed roller for painting without dipping or other preparation, thus speeding the operation and actually saving paint. The specially designed flexible roller conforms to rough surfaces and a three-foot aluminum extension greatly extends the painter's range. The tool is converted by a waxing head for waxing floors, also saving time and wax and preventing contamination of the wax. An adjustable spray nozzle may also be used with the tool for spraying other liquids. **Power-Flo Tools, 1348 Blue Jay Drive, Pittsburgh 16, Pa.**

For more details circle #972 on mailing card.

(Continued on page 260)

A continuing series of distinguished schools, office buildings, churches, hospitals and industrial structures using NORTON DOOR CLOSERS

NORTON'S PROVED DEPENDABILITY DICTATED CHOICE OF DOOR CLOSERS

ARCHITECT: HARRY T. MAC DONALD, A.I.A.
CONTRACTOR: STIGLBAUER BROTHERS

New Senior High School in Downey, Calif., Has a Norton Door Closer on Every Door

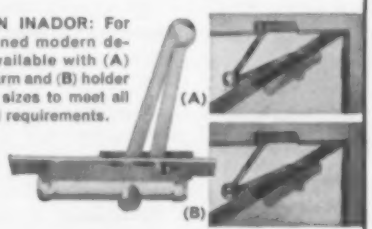
Ruggedness is a prime requisite for door closers in any school attended by over 2,000 students. This need has been satisfied in the distinctive new Senior High School at Downey, Calif. ...and also the new West Junior High School. All doors in both schools are equipped with Norton Door Closers. The choice was influenced by the fact that thousands of Norton Door Closers are still in daily use in some of America's best-known public buildings after serving continuously 30 years and longer. For fully illustrated data on these and other Norton Door Closers, including important new models, consult the current Norton catalog #57. Write for it today.

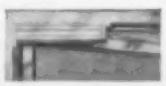
NORTON® DOOR CLOSERS

Dept. MH-118, Berrien Springs, Michigan

Complete Norton Line Meets Every Door Closer Need

NORTON INADOR: For streamlined modern design; available with (A) regular arm and (B) holder arm ... 4 sizes to meet all standard requirements.





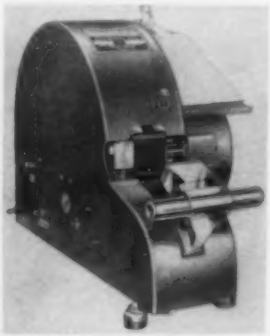
NORTON 750: New corner design with concealed arms, for all types of doors, particularly narrow-rail doors.

NORTON SURFACE-TYPE: For all installations where concealment is not essential.

NORTON 703E: Compact surface-mounted type ... first closer with extruded aluminum alloy shell.

Linen Marking Machine Provides Permanent Identification

Hospital linens can be permanently marked with a clean, uniform imprint with the Therm-O-Plate Machine. No ink is used in the machine, thus the die or plate cannot accumulate ink or lint. Quick-change dies or stock plates can be embossed by the hospital or at local offices



of Addressograph-Multigraph Corporation for use in the machine. A special Thermark Tape is used for the printing and provides a fresh surface for each imprint. Temperature, time and printing pressure are controlled by built-in features, making it possible for almost any personnel to do the marking. **Textile Marking Machine Co., Inc., 2204 Erie Blvd. E., Syracuse, N. Y.**

For more details circle #973 on mailing card.

Disposable Examination Mit Has Five Fingers

The five-finger Dispos-a-mit is a thin plastic glove for use in all types of examinations, treatments and other purposes where a glove is required for protection of the patient and of the hands. Its low cost permits discarding the glove immediately after use, saving time and labor of cleaning and preventing the possibility of cross infection. Dispos-a-mit provides protection without loss of sensitivity and protects hands in handling liquids and in various hygienic maintenance. The plastic mit is packed ready for immediate use. **Disposable Products Co., 17581 James Couzens Hwy., Detroit 35, Mich.**

For more details circle #974 on mailing card.

Calgomatic Control Analyzes Detergent Solution

Dishwashing in automatic machines is facilitated with the all-new electronic Calgomatic Detergent Control. The unit electronically analyzes detergent solution in the washing tank and, as dilution occurs, adds the exact amount of detergent necessary to maintain the desired concentrations. Safety check features permit automatic cut-off of dish machine operation when the detergent solution falls below proper concentration for cleaning, after giving ample advance warning. Audible and visual warnings before cut-off give the operator time to add the necessary detergent to ensure proper cleansing. A remote indicating light and buzzer can be set up if desired. **Calgon Co., 323 Fourth, Pittsburgh 22, Pa.**

For more details circle #975 on mailing card.

(Continued on page 262)

NOW SIMONIZ HEAVY-DUTY FLOOR WAX

shines like glass...wears like iron

Here is the heavy-duty wax you need for your heaviest traffic—an extremely tough, durable product formulated to withstand day-after-day pounding on your busiest floors.

Simoniz Heavy-Duty Floor Wax is the answer to high maintenance costs where traffic is a severe problem. Long-lasting, hard to wear off, it saves maintenance costs on any type floor. Dries quickly to a beautiful gloss, yet buffs excellently if a very high sheen is desired. Strips clean and easy without extra scrubbing.

Find out about Simoniz Heavy-Duty Floor Wax now. Write for details.

Available in 1-, 5-, 30-, and 55-gallon sizes

SIMONIZ®

FOR LONG WEAR—LESS CARE

Simoniz Company (Commercial Products Division—MH-11
2100 Indiana Avenue, Chicago 16, Illinois

☐ Without obligation, please send details on new Simoniz Heavy-Duty Floor Wax.

☐ Please send name of nearest Simoniz Distributor.

Name_____ Title_____

Firm Name_____

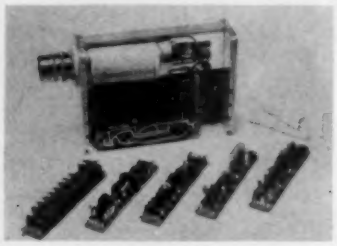
Street Address_____

City_____ State_____

For additional information, use postcard facing Cover 3.

Transistorized TV Camera Is Size of Book

A fully transistorized automatic television camera is now available from Dage



Television Division of Thompson Products. Including all of the technical features of broadcast equipment, the new miniature camera weighs approximately four pounds and is only 2¾ by 5¾ by 7¾ inches in size. The miniature size is possible since tubes are replaced with transistors and wires with printed circuits. The camera is self-contained, thus simplifying operation and handling. All necessary auxiliary equipment is built into the miniature unit which will operate on almost any power supply. **Dage Television Div., Thompson Products, Michigan City, Ind.**

For more details circle ₰976 on mailing card.

Sleep and Lounge Furniture for Dormitories and Housing

Duo-Executive is the name given to a new line of sleep and lounge furnishings suitable for use in nurses' homes, resident and other housing. The new group, which gives attractive living facilities during the day with comfortable sleeping units at night, is designed for use in any part of a

room, not necessarily in the corners.

The new line includes a combination desk-telephone-nightstand unit with the lounge-bed which is quickly converted. Several combinations are possible with the new line, using one or two beds, standard or double size, with the desk-nightstand table. Fingertip mobility on long conical rollers made of non-marking rubber, and trouble-free, mar-resistant finishes common to the Duo-Bed line are included in the new Duo-Executive group. **Duo-Bed Corp., 4153 Redwood Ave., Venice, Calif.**

For more details circle ₰977 on mailing card.

Fruit Filling and Spreads Add to Food Appeal

Two new fruit products are introduced by Gumpert. Icing and Filling Fruits in six flavors are one addition to the line. They are a special combination of heavily condensed fruits, plus concentrated flavors and colors, for use in icings, creams, cakes and fillings. The other addition is a fruit spread for use where a fruit filling will add flavor and appeal. The spread is offered as a blend of fresh oranges and pineapple, and also in raspberry. Both spreads have an abundance of true fruit and can be spread extremely thin and still give flavor and eye appeal. **S. Gumpert Co., Inc., 812 Jersey Ave., Jersey City 2, N. J.**

For more details circle ₰978 on mailing card.

Caddie Pill Pack Improves Medication Control

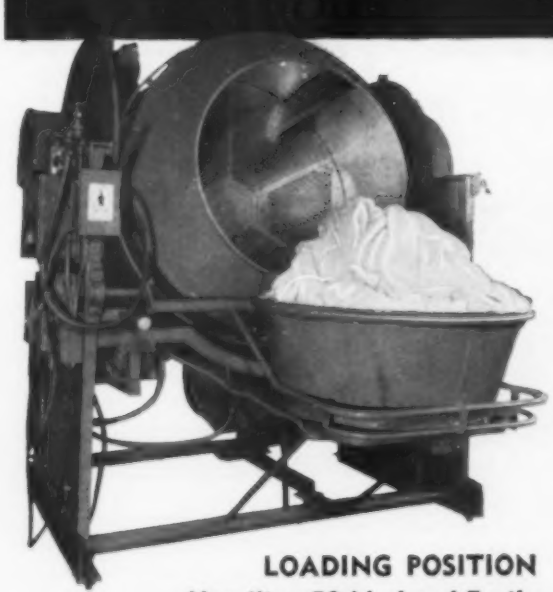
Economical price and improved control of medications are advantages claimed for

the new Caddie Nu-Method Pill Pack. The pack consists of a translucent plastic cup which holds up to twelve pills, with printed tab lid. The printed form contains sufficient space for the patient's name, room number and hours for medication, and is covered by a protective seal. The pertinent information on the lid eliminates constant checking of orders and personalizes the service to the patient. Portable plastic trays holding up to 25 of the packs are available for use in delivering medication to patients. **Caddie Creations, 712 S. Pulaski Rd., Chicago 24.**

For more details circle ₰979 on mailing card.

(Continued on page 264)

You'll say *"It's amazing... even unbelievable"*... when you see how the new Purkett 48" "Pre-Dryer" conditions flat work and garments



LOADING POSITION
Handling 50 Lb. Load Easily

UNLOADING POSITION
Shows Powerful Blower

Especially for the 1-ironer plant where formerly only the 72" size was available with Pre-Drying

Affectionately called "BIGMOUTH" this equipment . . .

1. Will keep your ironers working full capacity with improved quality throughout.
2. Removes one gallon additional moisture in 5 minutes tumbling time.
3. Eliminates re-runs by removing excessive moisture and keeping remainder properly distributed.
4. Increases production with less labor by eliminating costly hand shake-out . . . employee fatigue reduced.
5. Pays for investment in 12-18 months.

These and more advantages described in the new file folder on the 48" "BIGMOUTH" . . . It's yours for the asking.

PURKETT'S CONSULTING SERVICE . . . A Purkett specialized engineer will consult with you on your linen and garment conditioning problems . . . without obligation to you.

Naturally it's a PURKETT

Purkett equipment is sold by ALL Major Laundry Machinery Manufacturers and by

PURKETT MANUFACTURING COMPANY
Joplin, Missouri
DEPENDABLE PRE-DRYING CONDITIONING TUMBLERS

Dry Chemical Extinguishers Provide Fire-Killing Gas

Fire-killing gas is formed when dry chemical powder is sprayed from the new pressurized Fyr-Fyter extinguishers. Two sturdily-constructed, high-capacity dry chemical powder extinguishers with fast action pressurized squeeze-lever construction are now available in the Fyr-Fyter line. The two new models contain 20 and 30 pounds respectively of non-toxic and non-freezing powder which, as a non-conductor, can be used on Class C electrical fires and is effective against Class B flammable liquid fires. **Fyr-Fyter Div., 221 Crane St., Dayton 3, Ohio.**

For more details circle #980 on mailing card.

Nurse Station Desk Has Durable Plastic Top

Simplicity of line, durability of construction and finish and attractive appearance are features of the new TD series of low-

cost desks suited for nurse stations. Variety in finish is provided by the maintenance-free plastic tops and drawer fronts which are available in maple grain, beige, white or pastel blue. Colors can be used in attractive combinations for tops and drawer fronts. The desks are available with single or double pedestals. **The Jasper Desk Co., Jasper, Ind.**

For more details circle #981 on mailing card.

Keap Vegetable Shortening Made Especially for Frying

A new all-vegetable shortening made especially for frying is available in Keap. It has a high smoke point and stability to meet all the requirements for food frying. It has an unusually long frying life as well as long-keeping qualities, making it desirable for institutional frying operations. **Wesson Oil & Snowdrift Sales Co., 210 Baronne St., New Orleans 12, La.**

For more details circle #982 on mailing card.

Pharmaceuticals

Cosa-Tetrastatin

Cosa-Tetrastatin combines the broad-spectrum advantages of tetracycline potentiated with glucosamine and the antifungal properties of nystatin. It is described as providing highest, fastest and more consistent tetracycline blood levels and safe physiologic potentiation. Cosa-Tetrastatin is indicated for many types of common infections of respiratory, gastrointenstinal, genito-urinary, cutaneous, surgical and ocular origin caused by tetracycline-susceptible organisms. It is supplied in pink and black capsules in bottles of 16 and 100, and as an Oral Suspension in two-ounce bottles. **Pfizer Laboratories, 630 Flushing Ave., Brooklyn 6, N. Y.**

For more details circle #983 on mailing card.

Megimide

Megimide is a synthetic compound which acts on the central nervous system to counteract barbiturate depression or to restore protective reflexes following administration of intravenous barbiturates. It is administered intravenously in intermittent doses and is supplied in sterile 10 cc ampules. **Abbott Laboratories, North Chicago, Ill.**

For more details circle #984 on mailing card.

Tao Capsules or Oral Suspension

Tao, in capsule and liquid form, is designed for control of common infections. The product is therapeutically stable in gastric acid and has a high spectrum of antimicrobial efficacy against skin and soft tissue, urinary tract and general infections. Tao Capsules are supplied in 250 and 125 mg. strength in bottles of 60; Tao for Oral Suspension with palatable cherry flavor, in two-ounce bottles. **J. B. Roerig & Co., 800 Second Ave., New York 17.**

For more details circle #985 on mailing card.

Salundek Solution

Salundek Solution is a new dosage form of the antifungal preparation for treatment of ringworm of the scalp. Prompt use of the preparation destroys accessible spores and forms a protective coating over the infected area, reducing the likelihood of spread of the disease. The solution is supplied in three-ounce bottles with controlled flow applicator cap. **Maltbie Laboratories, Div. of Wallace & Tiernan, Inc., Belleville 9, N.J.**

For more details circle #986 on mailing card.

(Continued on page 266)

Literature and Services

• Good hospital publicity and how to achieve it is the theme of a "do-it-yourself" kit available from Shampaine Industries, 1920 S. Jefferson, St. Louis 4, Mo. Entitled **"How to Get Out of the Quiet Zone"** with Good Publicity for Your Hospital, the kit is designed to serve as a guide and contains a checklist of potential stories, sample news releases and facts on publicity procedures. The kit was prepared by Shampaine Industries' Public Relations consultants, Fleishman-Hillard, Inc., as a service to hospital administrators and other staff members who are non-professionals in publicity and would welcome assistance in planning publicity.

For more details circle #987 on mailing card.

• The handy **Soap and Detergent Buying Guide** issued by Colgate-Palmolive Co., 300 Park Ave., New York 22, is now available in the revised 1958 edition. Prepared by the Associated Products Department of the company, the pocket-size booklet gives complete information on more than 40 products in the Colgate line.

For more details circle #988 on mailing card.

• Specifications and general catalog information on the expanding line of General Floor Machines and E-Con-O-Vac Vacuum Cleaners for institutional use are available in a new **Floor Maintenance Catalog** offered by General Floorcraft, Inc., 421 Hudson St., New York 14. Data on each floor maintenance machine in the line are included.

For more details circle #989 on mailing card.

• How to achieve **"The Quiet Hospital"** is discussed in a 12-page brochure on sound conditioning prepared by The Celotex Corporation, 120 S. La Salle St., Chicago 3. Some of the subjects covered editorially in the brochure include "Sound Conditioning answers basic administrative problems," "where sound conditioning brings best results," and questions and answers on sound conditioning in the hospital. Information on Acousti-Celotex and on Celotex sound conditioning service are included.

For more details circle #990 on mailing card.

• **Brochure No. S-442** released by the Royal McBee Corporation, Port Chester, N.Y., discusses the use of the Keysort Requisition-Charge ticket by hospitals and clinics. How the ticket originates at nursing stations is illustrated with outline of the functions it performs at nursing stations, special service departments and business offices. The management reports resulting from processing the charge tickets are also outlined. Data are also included on the Keysort Data Punch.

For more details circle #991 on mailing card.

• A graphic illustration of the actual operation of the new **CircOlectric Universal Hospital Bed** which can be patient-operated is available in an unusual brochure available from the Orthopedic Frame Co., 420 Alcott St., Kalamazoo, Mich. Employing the technic of the motion picture, the little "flip-strip" booklet contains a series of action pictures of the bed in use. When the pages are riffled, the bed revolves before one's eyes and the model lies prone, sits, and finally steps off the bed at its vertical position, all in motion. It is a most helpful demonstration, in literature form, of the adaptability of the bed to all types of cases in medical and surgical fields, and should prove valuable to administrator, nurse, surgeon, orthopedist and others in seeing and showing the many advantages of this versatile bed.

For more details circle #992 on mailing card.

• Information on **Vaso-Pneumatic Operation and Treatment Methods**, and the instrument for this modality for arterial disease manufactured by Poor & Logan Mfg. Co., 7319 Varna Ave., North Hollywood, Calif., are presented in a folder. Specific data on the treatment and its action, with instructions for its use, are included. Also available is a small folder on "Circulation" with graphic illustrations in color showing the favorable results achieved with this treatment.

For more details circle #993 on mailing card.

• **"Diebold Steel Storage Files"** are the subject of a 12-page catalog recently released by Diebold, Inc., 818 Mulberry Rd. S.E., Canton, Ohio. The advantages of Diebold files for record storage, with detailed information on the wide range of sizes and styles available are included.

For more details circle #994 on mailing card.

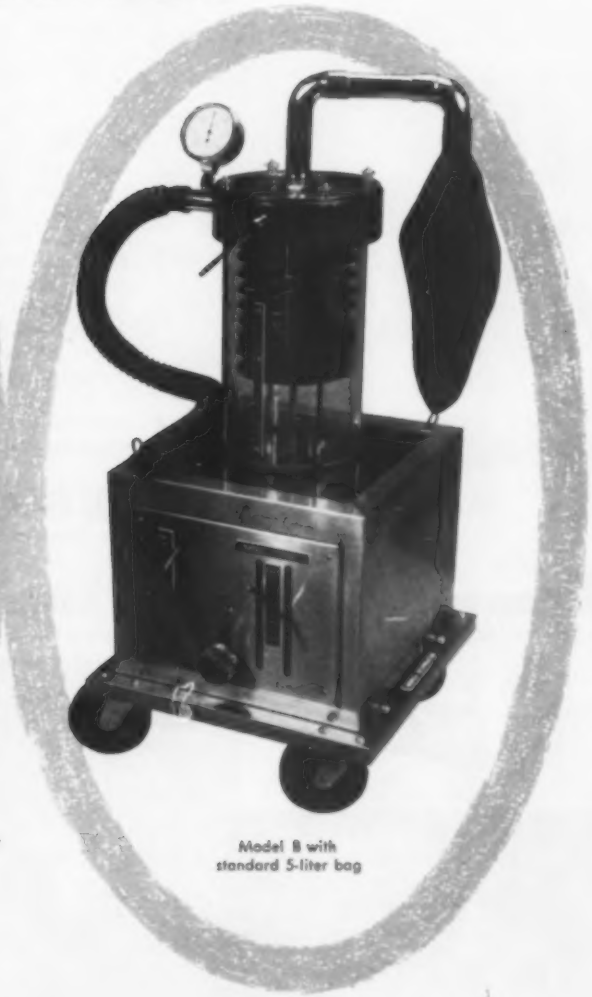
• All major features, benefits and uses of the completely redesigned line of **Waste King institutional garbage disposers** are discussed in the package of literature available from Waste King Corp., 3300 E. 50th St., Los Angeles 58, Calif.

For more details circle #995 on mailing card.

(Continued on page 268)

THE MÖRCH SURGICAL RESPIRATOR

Model A with accordion-type bag



Model B with standard 5-liter bag

provides safer, more efficient anesthesia

Connected to any anesthetic machine, the Mörch Surgical Respirator provides the safe, efficient, modern conditions demanded by present-day surgical techniques. It safeguards against insufficient respiration while it reduces the amount of anesthesia needed, provides a quieter surgical field, and relaxes the abdominal wall. This exceptional respirator, the result of two decades of research by an experienced anesthesiologist, also warns if the airways become obstructed. The Mörch Surgical Respirator is exclusively distributed by Liquid Carbonic.

GENERAL DYNAMICS CORPORATION
LIQUID CARBONIC DIVISION

Dept. 907 • 135 South La Salle Street • Chicago 3, Illinois

Resuscitation valve also available as optional accessory to convert Mörch Surgical Respirator to a portable resuscitator.

For additional information, use postcard facing Cover 3.

• A 44-page book on **"The New Dimensions of Modern Environmental Sanitation"** is available from Airkem, Inc., 241 E. 44th St., New York 17. Designed as an informative guide to understanding of the role of cleaning in an institution, and planned for use by the administrator, the booklet is practical as an instruction book for professional staffs and maintenance personnel.
For more details circle #996 on mailing card.

• The effectiveness of **Bionetic in institutional plumbing maintenance and waste treatment facilities** is discussed in a folder available from Reliance Chemicals Corp., P. O. Box 19343, Houston 24, Texas. What Bionetic is and how it works as a preventive maintenance product for kitchen drains, grease traps, plumbing lines and other waste systems is told in question and answer form in the informative folder.
For more details circle #997 on mailing card.

• Construction applications of Clad-Rex pre-finished wall panels for hospitals, schools, colleges, nurses' homes and other institutions are discussed in a booklet available from Clad-Rex Corp., Building Div., 2101 S. Indiana Ave., Chicago 16. **"Clad-Rex Wall Panels"** is an 8-page brochure with full-color illustrations of actual installations as well as color sketches of typical applications.
For more details circle #998 on mailing card.

• A number of **"idea sketches" for the architectural use of light fixtures** are presented in a new catalog released by Lighting Dynamics, 802 W. Whittier Blvd., Whittier, Calif. The sketches demonstrate many unique and unusual uses of fixtures in institutions. Technical and descriptive information on the fixtures is also given.
For more details circle #999 on mailing card.

• **Models T-7 and T-7A Champion Dish Washing Machines** are the subject of a folder released by Champion Dish Washing Machine Co., Erie, Pa. Specifications, descriptive information and detailed connection drawing of the single tank, "semi-automatic" and "automatic" door type machines are given in the folder.
For more details circle #1000 on mailing card.

• Instructions for the operation of the **Bruning Multicolor Kit No. 100** in making brilliant multicolor films and glossy prints from easily-made black and white translucent "originals" or "masters," are contained in a 24-page booklet available from Charles Bruning Co., Mount Prospect, Ill.
For more details circle #1001 on mailing card.

• The fascinating developments in Formica as a decorative mural material are discussed in a folder, **"New Dimensions in Decorative Art,"** released by Formica Corporation, 4614 Spring Grove Ave., Cincinnati 32, Ohio. The results achieved with the three technics of original paintings, artlay and inlay are illustrated, and information is given on some of the beautiful decorative possibilities of this medium. A sound stripfilm prepared by the company tells the story and illustrates examples in full color of the applications of the new technics.
For more details circle #1002 on mailing card.

(Continued on page 270)

4 ways hospitals can save money

by replacing worn casters with new top quality Bassicks

1. Rehabilitate used furniture and equipment. New casters often put new life into equipment you'd otherwise have to replace. A good point to consider in these budget-conscious times.

2. Reduce floor care and maintenance. With Bassick's new non-staining, non-marking, soft rubber tread Baco wheels, hospital floors last longer. New Bassick casters help hold those cleaning and polishing bills down, too.

3. Cut caster maintenance. Defective casters cost more to maintain than new casters do to buy. Bassick's sealed bearing construction (available on heavy and medium duty plate casters) holds maintenance to a once-a-year lubrication.

4. Save labor. When casters won't roll or swivel easily it takes more people more time to do the job. Here's where smooth rolling, easy swiveling casters can help you—by making things easier to move.

Your local Bassick distributor will be happy to show you how easily you can effect these and other savings. Call him. THE BASSICK COMPANY, Bridgeport 5, Conn. *In Canada:* Belleville, Ont.

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WHITE

Floor Cleaning Tools

White floor cleaning equipment is engineered to clean your floors properly and quickly — and to give years of efficient service. Top quality materials plus expert workmanship make White the best you can buy. And there are 252 cleaning items all under one brand name.

The famous Tymsaver single outfit shown below combines the oval bucket with the White "Can't Splash" wringer. At right is the double outfit with the White Eccentric Gear Downward Pressure Wringer. Either type wringer can be used with the single or the double outfit.

SEND FOR CATALOG NUMBER 156

WHITE MOP WRINGER CO.

9 MOHAWK ST. • FULTONVILLE, N.Y.

Canadian Factory: Paris, Ontario, Canada

The ONE complete line of floor cleaning tools

• Representative groupings of the complete Colson product lines are shown in the 24-page **Catalog** recently issued by The Colson Corp., Jonesboro, Ark. Included is descriptive information on the Colson hospital equipment line of inhalators, wheel chairs, orthopedic carts, wheeled stretchers, surgical carts and oxygen tank trucks, as well as casters, dollies, hand trucks and institutional dish, tray, shelf and laundry trucks.

For more details circle #1003 on mailing card.

• The Sterox-O-Matic system of gas sterilization is the subject of **Catalog Section 5** published by the Wilmot Castle Co., 1777 E. Henrietta Rd., Rochester 2, N. Y. Information on steroxcide gas sterilization with detailed descriptive data on the Castle Sterox-O-Matic system and the various units available are included in the brochure.

For more details circle #1004 on mailing card.

• A completely new catalog of **Sectional Cafeteria Equipment** manufactured by Stainless Food Equipment Co., 272 New St., Newark 3, N. J. is now available. Data on the comprehensive modular line, with two depths of equipment, are accompanied by illustrations of each individual item.

For more details circle #1005 on mailing card.

• **Bulletin 35** on **Speed Measuring Instruments** is available from James G. Biddle Co., 1316 Arch St., Philadelphia 7, Pa. It offers a wide selection of ranges and types of Hand Tachometers and other instruments, with specifications and descriptive information.

For more details circle #1006 on mailing card.

• **Detailed information** on all special purpose stainless steel sheet and strip grades produced by Washington Steel Corp., Washington, Pa., is presented in a new 32-page catalog on **"Microrold Special Purpose Stainless Steels."** Physical properties and analyses, corrosion and heat resistance, surface finishes, fabrication, maintenance and bacteria cleanability are some of the subjects covered.

For more details circle #1007 on mailing card.

• **Appleton Hospital Equipment** for "positive protection against fire and explosion hazards" is discussed in a 12-page brochure released by Appleton Electric Co., 1701 Wellington Ave., Chicago 13. Actual Appleton installations of explosion-proof equipment in hospitals are pictured and specifications and descriptive information on the products are presented.

For more details circle #1008 on mailing card.

• The new 8-page **Bulletin No. 2700** issued by the Ilg Electric Ventilating Co., 2850 N. Pulaski Rd., Chicago 41, gives full details on the complete line of **Type L-CRF Airfoil Centrifugal Power Roof Ventilators.** Maintenance-saving features of the line, data on new developments and specifications are included.

For more details circle #1009 on mailing card.

Book Announcements

Johnston, "Personnel Program Guide for Nursing Education and Nursing Service Agencies," 137 pp., $2.75. McKean, "Anatomy and Physiology, Laboratory Manual and Study Guide," 193 pp., $3. Stafford and Diller, "Surgery and Surgical Nursing," 3rd ed., 469 pp., $5. Von Oettinger, "Poisoning, a Guide to Clinical Diagnosis and Treatment," 2nd ed., 627 pp., $12.50. **W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa.**

For more details circle #1010 on mailing card.

Suppliers' News

Wear-Ever Aluminum, Inc., New Kensington, Pa. manufacturer of aluminum cooking and clinical utensils, announces its appointment as distributor of **Auto-Lock and Amphion hospital service trays** with stainless steel folding legs which stay locked in either upright or folded position.

Frederic Blank & Co., Inc., 203 Park Ave., New York 17, manufacturer of vinyl fabric-supported wall coverings, announces the opening of a new branch operation at **949 Maple Ave., Los Angeles 15, Calif.** The office, in charge of **Mr. Forrest Ferrin,** was opened to give better service to hospitals in the West Coast area.

The Pillsbury Company is the new corporate name of the company long known as **Pillsbury Mills, Inc., Minneapolis 2, Minn.,** manufacturer of milling and bakery products. The new corporate name was adopted as non-restrictive, permitting the company to produce and market numerous products both within and without the food industry.

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